

A young girl with dark hair in a braid, wearing an orange t-shirt with a graphic and a pink skirt with white stripes, is walking barefoot on a grey stone wall. She is looking down. The background shows a clear blue sky and some buildings in the distance.

Building Back Better

Sustainable Mental Health Care
after Emergencies



World Health
Organization

WHO Library Cataloguing-in-Publication Data

Building back better: sustainable mental health care after emergencies.

1.Mental health services. 2.Mental disorders. 3.Social support – organization and administration. 4.Conflict (Psychology). 5.Emergencies. 6.Case reports. I.World Health Organization.

ISBN 978 92 4 156457 1

(NLM classification: WM 30)

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For information and feedback on this document, please contact vanommerenm@who.int.

Suggested citation: World Health Organization (WHO). *Building back better: sustainable mental health care after emergencies*. WHO: Geneva, 2013.

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Building Back Better

Sustainable Mental Health Care after Emergencies

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Foreword

Already in 2013, the world has witnessed numerous emergency situations, including the refugee crisis in Syria and neighbouring countries; heavy fighting in the Central African Republic, Democratic Republic of Congo, and Mali; and major flooding in Bolivia, Colombia, Mozambique, and the Philippines. Countless people have been affected, and will continue to be affected as their countries struggle to recover and rebuild.

Displacements, food shortages, and disease outbreaks are all-too-common during and after emergencies. On top of this, families can be torn apart, children can lose educational opportunities, and important social and health services can disappear from the landscape overnight.

It is perhaps not surprising, therefore, that the mental health impact of emergencies is sizeable. Emergency situations can trigger or worsen mental health problems, often at the same time that existing mental health infrastructure is weakened. Humanitarian assistance agencies try their best to help people with their psychosocial needs in the immediate aftermath of emergencies, but too often do little to strengthen mental health systems for the long term.



It is possible to do better. Emergency situations – in spite of the adversity and challenges they create – are openings to transform mental health care. These are opportunities not to be missed because mental, neurological and substance use disorders are among the most neglected problems in public health, and because mental health is crucial to the overall well-being and productivity of individuals, communities, and countries recovering from emergencies.

This WHO report shares detailed accounts from 10 diverse emergency-affected areas, each of which built better-quality and more sustainable mental health systems despite challenging circumstances. Cases originate from countries small to large; low- to middle-income; across Africa, Asia, Europe, and the Middle East; and affected by large-scale natural disasters, prolonged conflict, and large-scale influxes of refugees. While their contexts varied considerably, all were able to convert short-term interest in population mental health into sustainable, long-term improvements.

This WHO report goes beyond aspirational recommendations by providing detailed descriptions of how mental health reform was accomplished in these situations. Importantly, case contributors report not only their major achievements, but also their most difficult challenges and how they were overcome. Key overlapping practices emerging from these experiences are also summarized.

This report provides the proof of concept that it is possible to build back better, no matter how weak the existing mental health system or how challenging the emergency situation. I call upon all readers to take steps to ensure that those faced with future emergencies do not miss the important opportunity for mental health reform and development.

A handwritten signature in black ink, reading "M. Chan".

Dr Margaret Chan

Director-General
World Health Organization

Preface

Emergency situations have a range of causes: natural disasters such as earthquakes and floods, armed conflicts and civil wars, and technological failures such as nuclear disasters. Regardless of the nature of the triggers, a cascade of human suffering is often the result. This can include large-scale displacements, food shortages, outbreaks of disease, violations of people's rights and dignity, and death.

But the human impact is even broader: after emergencies, people are more likely to suffer from a range of mental health problems. A minority develops new and debilitating mental disorders; many others are in psychological distress. And those with pre-existing mental disorders often need even more help than before. When the plight of those suffering becomes known to the nation and the world, others often become motivated to provide assistance.

And herein lies the paradox. In spite of their tragic nature, and notwithstanding the human suffering they create, emergency situations are also opportunities to build better mental health care. The surge of aid, combined with sudden, focused attention on the mental health of the population, creates unparalleled opportunities to transform mental health care for the long term.

As this publication demonstrates, some countries have done just this. They range from those undergoing prolonged conflict to those struck by devastating natural disasters. While the circumstances of each have been unique, all – using their own methods – have found ways to use the situation to build momentum for broader mental health reform.

The results can have an immediate and important human impact. For example, Razmy,¹ a teenage girl living in the tsunami-affected district of Kalmunai in Sri Lanka, was able to get help for both her parents following the 2004 disaster. Razmy heard a talk at her school by a newly appointed community mental health worker, and later asked the worker to visit her mother, who had become withdrawn and was hearing voices. The worker quickly identified her need for mental health services, but first had to overcome resistance by Razmy's family to her seeking care. Once this was accomplished, Razmy's mother was connected to the new mental health services in Kalmunai that she so needed. Later, Razmy's father disclosed to the community health worker his desire to deal with his alcohol use disorder. As a result, he was also able to access care.

The experience of Razmy's family is not unique. Countless families have been helped around the world as the result of mental health reform following emergencies.

¹ A pseudonym

The 10 cases that form the core of this report show how it can be done. Early commitment towards a longer-term perspective for mental health reform is key to success. The report summarizes lessons learnt and key overlapping practices emerging from these experiences.

By publishing this information, the World Health Organization aims to ensure that people faced with

emergencies do not miss the opportunity for mental health reform. Emergencies are not only mental health tragedies, but also powerful catalysts for achieving sustainable mental health care in affected communities. We do not know where the next major emergency will be, but we do know that those affected will have the opportunity to build back better. Reading this publication is an excellent way to prepare for and respond to that eventuality.

Shekhar Saxena

Director, Department of Mental Health
and Substance Abuse

World Health Organization

Richard Brennan

Director, Department of Emergency Risk
Management and Humanitarian Response

World Health Organization

Acknowledgements

WHO coordination and supervision

Mark van Ommeren (Scientist, Department of Mental Health and Substance Abuse, World Health Organization, Geneva, Switzerland) initiated and coordinated the development and production of this publication.

Shekhar Saxena (Director, Department of Mental Health and Substance Abuse, World Health Organization, Geneva, Switzerland) provided overall direction and supervision.

Managing editor

JoAnne Epping-Jordan (Seattle, USA) served as managing editor.

Contributors

JoAnne Epping-Jordan (Seattle, USA) and Mark van Ommeren (WHO/Geneva) wrote Parts 1 and 3, which introduce, justify, and analyze mental health reform and emergency recovery.

The following people contributed the case studies featured in Part 2.

AFGHANISTAN

Peter Ventevogel (HealthNet TPO), Bashir Ahmad Sarwari (Ministry of Public Health, Afghanistan), Inge Missmahl (International Psychosocial Organisation), Hafiz Faiz (International Medical Corps), Heini Mäkilä (International Assistance Mission), and Fareshta Queedes (International Psychosocial Organisation).

BURUNDI

Peter Ventevogel (HealthNet TPO), Herman Ndayisaba (HealthNet TPO), Willem van de Put (HealthNet

TPO), Nancy Baron (Global Psycho-Social Initiatives and Psycho-Social Services and Training Institute), Joop de Jong (University of Amsterdam, Boston University and Rhodes University), Jérôme Ndaruhutse (WHO/Burundi), Jocelyne Miburu (Ministry of Public Health, Burundi), Wilma Meeus (HealthNet TPO), and Sonali Sharma (HealthNet TPO).

INDONESIA (ACEH) (alphabetical)

Albert Maramis (WHO/Indonesia) and Andrew Mohanraj (CBM Indonesia).

IRAQ (alphabetical)

Emad Abdulrazaq (Ministry of Health, Iraq), Ayad Nouri Fattah (Ministry of Health, Iraq), Manhal Helasa (WHO/Iraq Office in Amman), Aqila Noori (WHO/Iraq Office in Amman), and Nezar Ismet Taib (Mental Health Centre, Duhok, Kurdistan region, Iraq).

JORDAN

Anita Marini (formerly WHO/Jordan), Hashim Elzein Elmousaad (formerly WHO/Jordan), Nada Al Ward (WHO/Jordan), Zein Ayoub (WHO/Jordan), Bassam Hijawi (Ministry of Health, Jordan), Hania Dawani (Jordanian Nursing Council), Mohammad Assfour (National Mental Health Centre, Jordan), Zuhair Zakaria (Jordanian Psychological Association), Tewfik Daradke (Jordanian University of Science and Technology), Abdel Majeed (Jordan University), Mary Jo Baca (International Medical Corps), Father Fadi Diab (Episcopal Church), Hamdi Murad, (Jordan), and Our Step (Jordanian National Users Association).

KOSOVO (alphabetical)

Ferid Agani (Ministry of Health, Kosovo), Dévora Kestel (PAHO/WHO), Besnik Stuja (WHO/Pristina),

Skender Sylva (WHO/Pristina), and Liliana Urbina (formerly WHO/Pristina).

SOMALIA

Humayun Rizwan (WHO/Somalia), Mohammad Fuje (WHO/Somalia), Martha Everard (WHO/Somalia), Khalid Saeed (WHO/Cairo), and Abdur Rehman Ali Awale (Habeab Hospitals, Somalia).

SRI LANKA

T Suveendran (WHO/Sri Lanka), FR Mehta (WHO/Sri Lanka), Jayan Mendis (National Institute of Mental Health, Sri Lanka), M Ganesan (National Institute of Mental Health, Sri Lanka), TRC Ruberu (Ministry of Health, Sri Lanka), PG Mahipala (Ministry of Health, Sri Lanka), Prasantha de Silva (Ministry of Health, Sri Lanka), Lakshmi C Somatunga (formerly Director of Mental Health, Ministry of Health, Sri Lanka) Berit Kieselbach (formerly WHO/Sri Lanka), and John Mahoney (formerly WHO/Sri Lanka).

TIMOR-LESTE

Derrick Silove (University of New South Wales), Teofilo Julio Kehic Tilman (Department of Mental Health, Timor-Leste), and Zoe Hawkins (formerly Ministry of Health, Timor-Leste).

WEST BANK AND GAZA STRIP

Hazem Ashour (Ministry of Health, Palestinian Authority), Nargiza Khodjaeva (formerly WHO/West Bank and Gaza), Dyaa Saymah (WHO/West Bank and Gaza), Rajiah Abu Sway (WHO/West Bank and Gaza), and Tony Laurance (WHO/West Bank and Gaza).

Expert reviewers

The following people reviewed draft versions of this publication or parts thereof and provided comments and guidance on its further development.

Stephen Alderman (Peter C. Alderman Foundation), Dan Chisholm (WHO/Geneva), Julian Eaton (CBM International), Michelle Funk (WHO/Geneva), Berit Kieselbach (WHO/Geneva), Dévora Kestel (PAHO/WHO/Washington), Thierry Liscia (Agence Française de Développement (AFD)), John Mahoney (formerly WHO/Sri Lanka), Anita Marini (formerly WHO/Jordan), Claire Milligan (Absolute Return for Kids), Harry Minas (University of Melbourne), Andrew Mohanraj (CBM Indonesia), Matt Muijen (WHO/Copenhagen), Arne Ørum (Norwegian Council for Mental Health), Pau Perez-Sales (Médicos del Mundo [MdM-Spain]), Benedetto Saraceno (Universidade Nova de Lisboa), Khalid Saeed (WHO/Cairo), Alison Schafer (World Vision International), Yutaro Setoya (WHO/Geneva), Mathias Themel (European Commission), Graham Thornicroft (King's College London), Peter Ventevogel (HealthNet TPO), Xiangdong Wang (WHO/Manila), and Inka Weissbecker (International Medical Corps).

Technical editing

David Wilson (Oxford, United Kingdom)

Graphic design and layout

Alessandro Mannocchi (Rome, Italy)

Support by interns

Michelle Hourigan and Karen Paul (WHO/Geneva)

Administrative support

Mylène Schreiber (WHO/Geneva) and Grazia Motturi (WHO/Geneva)

Funding

The development and production of this publication were funded by WHO, CBM, and – for the Jordan case study – the United States of America.

List of abbreviations

ADB	Asian Development Bank
BPHS	Basic Package of Health Services (Afghanistan)
CMHC	Community mental health centre (Jordan)
CSO	Community support officer (Sri Lanka)
CWGER	Cluster Working Group on Early Recovery
EC	European Community
ECHO	European Community Humanitarian Office
EPHS	Essential Package of Hospital Services (Afghanistan)
IASC	Inter-Agency Standing Committee
KTSP	King's THET Somaliland Partnership
mhGAP	WHO Mental Health Gap Action Programme
MOH	Ministry of Health
MOPH	Ministry of Public Health
NGO	Nongovernmental organization
NMHAC	National Mental Health Advisory Council (Sri Lanka)
NMHC	National Mental Health Council (Iraq)
NMHP	National Mental Health Policy (West Bank and Gaza Strip)
PHC	Primary health care
PTSD	Post-traumatic stress disorder
PRADET	Psychosocial Recovery and Development in East Timor
SLCP	Sri Lanka College of Psychiatrists
TFG	Transitional Federal Government (Somalia)
TPO	Transcultural Psychosocial Organization
UNDP	United Nations Development Programme
UNMIK	UN Interim Administration Mission in Kosovo
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
USAID	United States Agency for International Development
WHO	World Health Organization
WHO-AIMS	WHO-Assessment Instrument for Mental Health Systems

Executive summary

Emergencies, in spite of their tragic nature and adverse effects on mental health, are also unparalleled opportunities to improve the lives of large numbers of people through mental health reform.

This is important because mental health is crucial to the overall well-being, functioning, and resilience of individuals, societies, and countries recovering from natural disasters, armed conflicts, or other hazards.



Sierra Leone. © Tommy Trenchard/IRIN. Reprinted with permission.

Building back better: sustainable mental health care after emergencies raises awareness about this type of opportunity, and describes how this was achieved in 10 diverse emergency-affected areas. Lessons learnt and key overlapping practices emerging from these experiences are summarized.

By publishing this report, the World Health Organization (WHO) aims to ensure that people faced with emergencies do not miss the opportunity for mental health reform and development.

The report is divided into three distinct parts.

Part 1

Part 1 provides the rationale for understanding emergencies as opportunities to build better mental health care.

During emergencies, mental health requires special consideration. This is due to three common issues: increased rates of mental health problems, weakened mental health infrastructure, and difficulties coordinating agencies and actors providing mental health and psychosocial support.

Emergencies present unique opportunities for better care of all people with mental health needs. During and immediately after emergencies, the media often rightly focus on the plight of surviving people, including their psychological responses to the stressors they face. In some countries, senior government leaders express – for the first time – serious concern about their nation’s mental health. This is frequently followed by the willingness and financial ability of national and international agencies to support mental health and psychosocial assistance to affected people. In other words, in emergencies attention and resources are turned towards the psychological welfare of affected people, while decision-makers become willing to consider options beyond the status quo.

Collectively, these factors create the possibility of introducing and implementing more sustainable mental health services. But momentum needs to be generated at an early stage so that investments continue after an acute crisis.

The possibilities presented by emergency situations are significant because major gaps remain worldwide in the realization of comprehensive, community-based mental health care. This is especially true in low- and middle-income countries, where resources are often scant.

Countries faced with emergencies should not miss the chance to use available political will for change and to initiate mental health reform.



Indonesia (Aceh). © Jefri Aries/IRIN. Reprinted with permission.

Part 2

Part 2 presents 10 case examples of areas that have seized opportunities during and after emergencies to build better mental health care. They represent a wide range of emergency situations and political contexts. Still largely unknown, they offer proof of concept that it is possible to take action in emergencies to make systemic change to build better mental health systems. Lessons learnt are highlighted within each account.

Afghanistan: Following the fall of the Taliban government in 2001, mental health was declared a priority health issue and was included in the country's Basic Package of Health Services. Much progress has been made. For example, since 2001, more than 1000 health workers have been trained in basic mental health care and close to 100 000 people have been diagnosed and treated in Nangarhar Province.

Burundi: Modern mental health services were almost non-existent prior to the past decade, but today the government supplies essential psychiatric medications through its national drug distribution centre, and outpatient mental health clinics are established in several provincial hospitals. From 2000 to 2008, more than 27 000 people were helped by newly established mental health and psychosocial services.

Indonesia (Aceh): In a matter of years following the tsunami of 2004, Aceh's mental health services were transformed from a sole mental hospital to a basic system of mental health care, grounded by primary health services and supported by secondary care offered through district general hospitals. Now, 13 of 23 districts have specific mental health budgets, compared with none a decade ago. Aceh's mental health system is viewed as a model for other provinces in Indonesia.

Iraq: Mental health reform has been ongoing since 2004. Community mental health units now function within general hospitals, and benefit from more stable resources. Since 2004, 80–85% of psychiatrists, more than 50% of general practitioners, and 20–30% of nurses, psychologists, and social workers working in the country have received mental health training.

Jordan: The influx of displaced Iraqis into Jordan drew substantial support from aid agencies. Within this context, community-based mental health care was initiated. The project's many achievements built momentum for broader change across the country. New community-based mental health clinics helped more than 3550 people in need from 2009 to 2011.

Kosovo:² After the conflict, rapid political change generated an opportunity to reform Kosovo's mental health system. A mental health taskforce created a new strategic plan to guide and coordinate efforts. Today, each of Kosovo's seven regions offers a range of community-based mental health services.

Somalia: The governance structure in Somalia has been fragmented for more than 20 years, and during most of that time the country has been riddled with conflict and emergencies. Despite these challenges, mental health services have improved. From 2007 to 2010, chains were removed from more than 1700 people with mental disorders.

Sri Lanka: In the aftermath of the 2004 tsunami, Sri Lanka made rapid progress in the development of basic mental health services, extending beyond tsunami-affected zones to most parts of the country. A new national mental health policy has been guiding the development of decentralized and community-based care. Today, 20 of the country's 27 districts have mental health services infrastructure, compared with 10 before the tsunami.

Timor-Leste: Building from a complete absence of mental health services in 1999, the country now has a comprehensive community-based mental health system. Today, the Timor-Leste National Mental Health Strategy is part of the Ministry of Health's overall long-term strategic plan. Mental health-trained general nurses are available in around one quarter of the country's 65 community health centres, compared with none before the emergency.

West Bank and Gaza Strip: Significant improvements in the mental health system have been made over the past decade, towards community-based care and integration of mental health into primary care. In 2010, more than 3000 people were managed in community-based mental health centres across the West Bank and Gaza Strip.

² Throughout this document the name Kosovo is used in accordance with United Nations Security Council Resolution 1244 (1999).

Part 3

Part 3 summarizes overlapping practices among the 10 cases. Despite substantial variability in their contexts, certain commonalities can be identified between many cases.

1. **Mental health reform was supported through planning for long-term sustainability from the outset.** As demonstrated by several cases in this report, successful mental health reform commenced meaningfully in the midst of emergencies when an early commitment was made towards a longer-term perspective for mental health reform.
2. **The broad mental health needs of the emergency-affected population were addressed.** In many cases in this report, reforms were undertaken that addressed a wide range of mental health problems. No case established stand-alone (vertical) services for just one disorder (e.g. post-traumatic stress disorder) that ignored other mental disorders.
3. **The government's central role was respected.** During and following some of the emergencies described in this report, government structures were adversely affected but humanitarian aid helped subsequently to strengthen them. Examples included seconding professional staff and temporarily assigning certain functions to nongovernmental organizations (NGOs) under government oversight.
4. **National professionals played a key role.** Local professionals – even when they were too few in number – were powerful champions in promoting and shaping mental health reform. Helpful international experts and agencies involved themselves in mental health reform only to the extent that they were specifically invited to do so.
5. **Coordination across agencies was crucial.** Coordination of diverse mental health actors was typically crucial when working towards mental health reform. It helped facilitate consensus among diverse partners and then worked from an agreed framework. It also often helped partners complement – as opposed to duplicate – one another by taking different areas of responsibility.
6. **Mental health reform involved review and revision of national policies and plans.** Most cases featured in this report describe an overall process that involved policy reform. In the context of disaster, when political will for mental health care was high, the policy reform process was typically accelerated.
7. **The mental health system was considered and strengthened as a whole.** Many cases described processes that reviewed and assessed the mental health system as a whole, from community level to tertiary care level. Doing so provided an understanding of the overall system and how it was affected by the emergency. Decentralization of mental health resources towards community-based care was a key strategy.
8. **Health workers were reorganized and trained.** Opportunities frequently arose post-emergency to reorganize, train, and provide ongoing supervision to health workers so that they were better equipped to manage mental health problems. The majority of investments were made in people and services, rather than in buildings.
9. **Demonstration projects offered proof of concept and attracted further support and funds for mental health reform.** Demonstration projects provided proof of concept. They also helped ensure momentum for longer-term funding. The latter was particularly true when the demonstration projects were explicitly linked to discussions and plans on broader mental health reform.
10. **Advocacy helped maintain momentum for change.** Almost all cases featured in this report described individuals or groups who became successful advocates of broader mental health reform. They helped maintain momentum for change. Advocacy was most successful when diverse groups of people were not only informed about the issues, but also asked to become part of the solution.



Somalia. © Kate Holt/IRIN. Reprinted with permission.

The cases featured in this report show that mental health reform is realistic as part of recovery from crisis, even in highly challenging circumstances. Although the majority of mental health investments were directed towards humanitarian relief, exceptional efforts were made to redirect a portion towards mental health reform. The 10 practices summarized above were likely key in achieving success.

Global progress on mental health reform will happen more quickly if, in every crisis, strategic efforts are made to convert short-term interest in mental health problems into momentum for mental health reform. This would benefit not only people's mental health, but also the functioning and resilience of societies recovering from emergencies. Readers are encouraged to review these cases to consider how the overlapping practices and lessons learnt can be applied in their own situations.

Part 1.

Seeing Opportunity In Crisis: Using Emergencies to Build Better Mental Health Care



Iraq. © Jodi Hilton/IRIN. Reprinted with permission.

Natural disasters, armed conflict, and other hazards affect millions of people around the world. They can result in emergency situations involving large-scale injury and death, insecurity, displacement of people, malnutrition, disease, and disrupted economic, political, health, and social institutions. In 2011 alone, natural disasters caused the deaths of more than 30 000 people, affected 245 million more, and caused an estimated US\$ 366 billion in damages (1).

Mental health challenges

During emergencies, mental health requires special consideration. This is due to three common issues: increased rates of mental health problems, weakened mental health infrastructure, and difficulties in coordinating agencies that are providing mental health relief services.

First, rates of a wide range of mental health problems increase as the result of emergencies (see Table 1). Within conflict-affected populations, robust studies (those using random samples and diagnostic interviews) have shown that the prevalence of depression and post-traumatic stress disorder (PTSD) increases substantially (2). A range of mental health problems – not only PTSD – are concerning: the ongoing needs and vulnerabilities of people with pre-existing severe mental disorders such as schizophrenia or bipolar disorder; those with pre-existing or emergency-induced mood, anxiety, and alcohol and drug use disorders; and the vast number of people who do not have mental disorders but experience psychological distress.

Increased rates of mental disorders translate into a greater need for services across a broad spectrum of the population. Aside from increased need, demand for mental health care can increase as a result of it

being accessible for the first time, when it is introduced by humanitarian medical services (4, 5).

Second, and simultaneous with the increased needs and demand for services, existing mental health infrastructure may be weakened as a result of emergencies. Buildings can be damaged, electricity and water supplies can be affected, and supply lines for essential medicines can be disrupted. Health workers may themselves fall victim to the emergency situation through injury, death, or forced displacement. In some cases, they need to look after their own families or friends before fulfilling their professional duties. This can create critical shortages of qualified health workers who can attend to the mental health needs of the population. The situation is sometimes compounded when nongovernmental agencies recruit government mental health professionals and appoint them to positions that focus on the promotion of well-being for the broad population. As a result, people who were previously receiving mental health care may no longer have access.

These treatment gaps are significant because poor mental health impedes an individual's capacity to work productively, and can lead to worsened poverty (6). As shown by 19 national mental health surveys, untreated mental disorders negatively affect economic development at the societal level. The economic impact of lost productivity on national earnings is massive: equivalent to billions of dollars foregone on an annual basis (7).

Third, during major emergencies with acute onset, a sudden surge of aid agencies into a country can result in a chaotic situation, in which it can be nearly impossible to keep track of who is providing support and what they are doing (8). Coordination of aid

Table 1. World Health Organization projections of mental disorders in adult populations affected by emergencies

	Before the emergency: 12-month prevalence ^a	After the emergency: 12-month prevalence ^b
Severe disorder (e.g. psychosis, severe depression, severely disabling form of anxiety disorder)	2–3%	3–4% ^c
Mild or moderate mental disorder (e.g. mild and moderate forms of depression and anxiety disorders, including mild and moderate PTSD)	10%	15–20% ^d
Normal distress (no disorder)	No estimate	Large percentage

Notes: Adapted from WHO (2005; 3). PTSD indicates post-traumatic stress disorder.

^a The assumed baseline rates are median rates across countries as observed in World Mental Health Surveys.

^b The values are median rates across countries. Observed rates vary with assessment method (e.g. choice of assessment instrument) and setting (e.g. time since the emergency, sociocultural factors in coping and community social support, previous and current exposure to adversity).

^c This is a best guess based on the assumption that traumatic events and loss may contribute to a relapse in previously stable mental disorders, and may cause severely disabling forms of mood and anxiety disorders.

^d It is established that traumatic events and loss increase the risk of depression and anxiety disorders, including PTSD.

agencies is resource-intensive, but failure to coordinate services creates duplication of efforts, while segments of the population remain underserved.

Other risks associated with the rapid influx of mental health and psychosocial assistance in the acute phase of emergencies include an over-focus on PTSD while other mental health problems are ignored (9, 10, 11). Treatments without empirical support or which are culturally inappropriate are all too common, and may result in psychological harm. Stand-alone programmes do little to strengthen existing mental health systems, and in fact can damage public health infrastructure through the drain of health professionals and other resources to these parallel structures.

Mental health opportunities

While the challenges related to mental health care are considerable, emergencies also present unique opportunities for better care of all people with mental health needs. Following disasters, the media often focus on the plight of surviving people, including their psychological responses to the stressors they face. In some countries, senior government leaders express – for the first time – serious concern about their nation’s mental health. This is frequently followed by national and international agencies’ willingness and financial ability to support mental health and psychosocial assistance to affected people.

Collectively, these factors create the possibility of introducing and implementing more sustainable mental health services. This is important because

mental health is crucial to the overall well-being, functioning, and resilience of individuals, societies, and countries recovering from emergencies. Positive mental health has been linked to a range of development outcomes, including better health status, higher educational achievement, enhanced productivity and earnings, improved interpersonal relationships, better parenting, closer social connections, and improved quality of life (6).

But momentum needs to be generated at an early stage so that investments continue after an acute crisis. The following section describes how actions in the framework of *early recovery*³ during an emergency can lay the groundwork for longer-term *mental health reform*.⁴

Mental health care during emergencies and early recovery

The Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings (12) and the Sphere Handbook (13) provide consensus-based guidance and standards on mental health services and community psychosocial supports during emergencies, including early recovery. They are consistent with available evidence and stress that emergency-affected people need different types of support. A layered set of supports is depicted in the form of a pyramid (see Figure 1). Services become more focused, specialized, and costly (per person helped) towards the tip of the pyramid. Collectively, the support layers aim to meet the needs of different people in a complementary manner.

Important in their own right, the layers of support recommended by IASC and Sphere in emergency settings can become the basis for developing mental health care *after* emergencies. As described in the next section, the optimal mix of services for mental health systems is broadly consistent with the IASC- and Sphere-recommended layers of support.

Mental health care over the long term

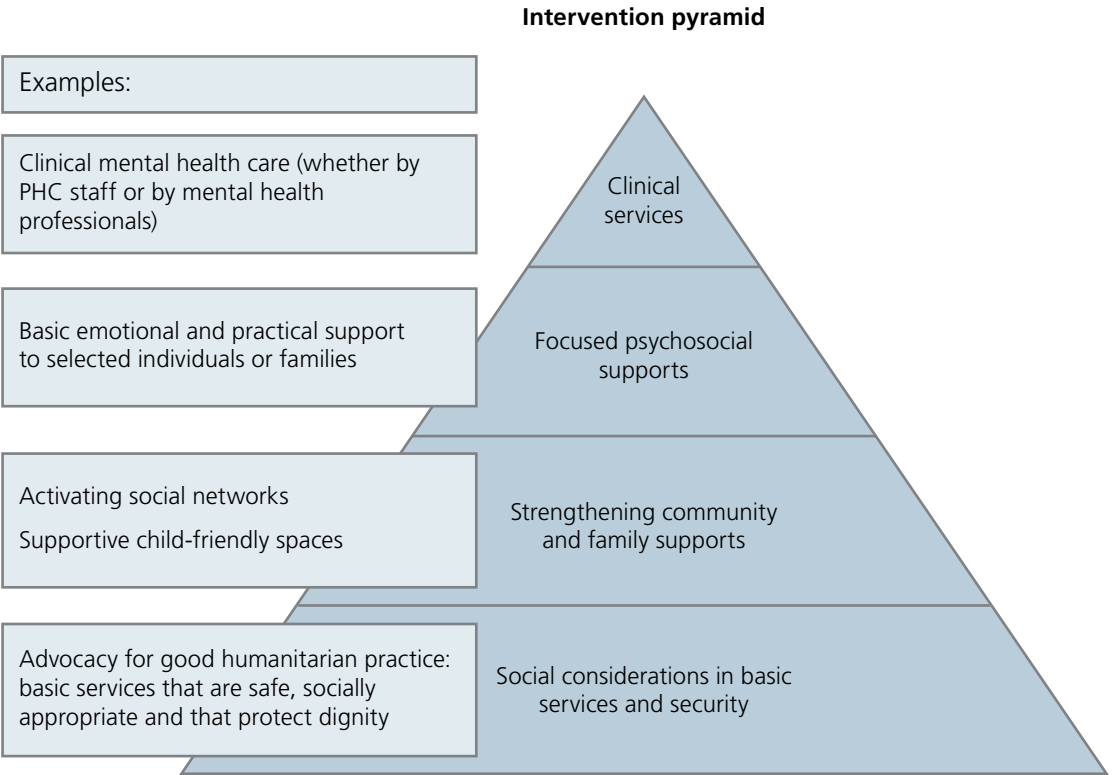
WHO has affirmed that mental health care in all countries – including those rebuilding from emergencies – should be centred on services that are accessible in the community (14, 15). While community-based mental health care needs to be expanded, long-stay psychiatric hospitals need to be downsized or re-purposed. In addition, action is almost always needed to reduce discrimination and human rights violations (16).

The WHO Service Organization Pyramid describes the mix of services needed to achieve this type of mental health care (see Figure 2; 17, 18). It is based on the principle that no single service level can meet all of a population's mental health needs. Self-care, informal community care, and primary mental health care form the base of the model. These levels are where the majority of care should be located (17–20). For those requiring more intensive services at some point in their lives, outpatient care and short-stay inpatient care should be available through secondary care (e.g. through general hospitals or community mental health centres). Only a tiny fraction of those with severe mental disorders will require long-stay

³ The term “early recovery” is used by the Cluster Working Group on Early Recovery and the United Nations Development Programme (UNDP) to refer to activities that begin during or immediately after crises and seek to bring national and international capacity to bear on restoring local capacity to provide a secure environment, offering services, restoring livelihoods, coordinating activities, preventing the recurrence of crisis, and creating conditions for future development.

⁴ This report uses the term “mental health reform” to describe the process of changing the organization and configuration of mental health services.

Figure 1. The IASC and Sphere Project intervention pyramid for mental health and psychosocial support in emergencies (adapted with permission) (12)



services. Importantly, such services should not be equated with the psychiatric hospitals that dominated mental health care during the 20th century, and that continue to overshadow other mental health services in many countries.

Across all levels, the model emphasizes that people with mental health problems need to be involved in the self-management of their conditions. Clear referral, back-referral, and linkage systems are needed to connect health workers at all service levels and with other sectors.

In most countries, successful implementation of the WHO service pyramid requires systemic changes. Commitment from government, and formal policies, legislation, and regulations that concretize this commitment, are essential. Developing an extended group of partners and collaborators from different sectors, service users, and the wider community

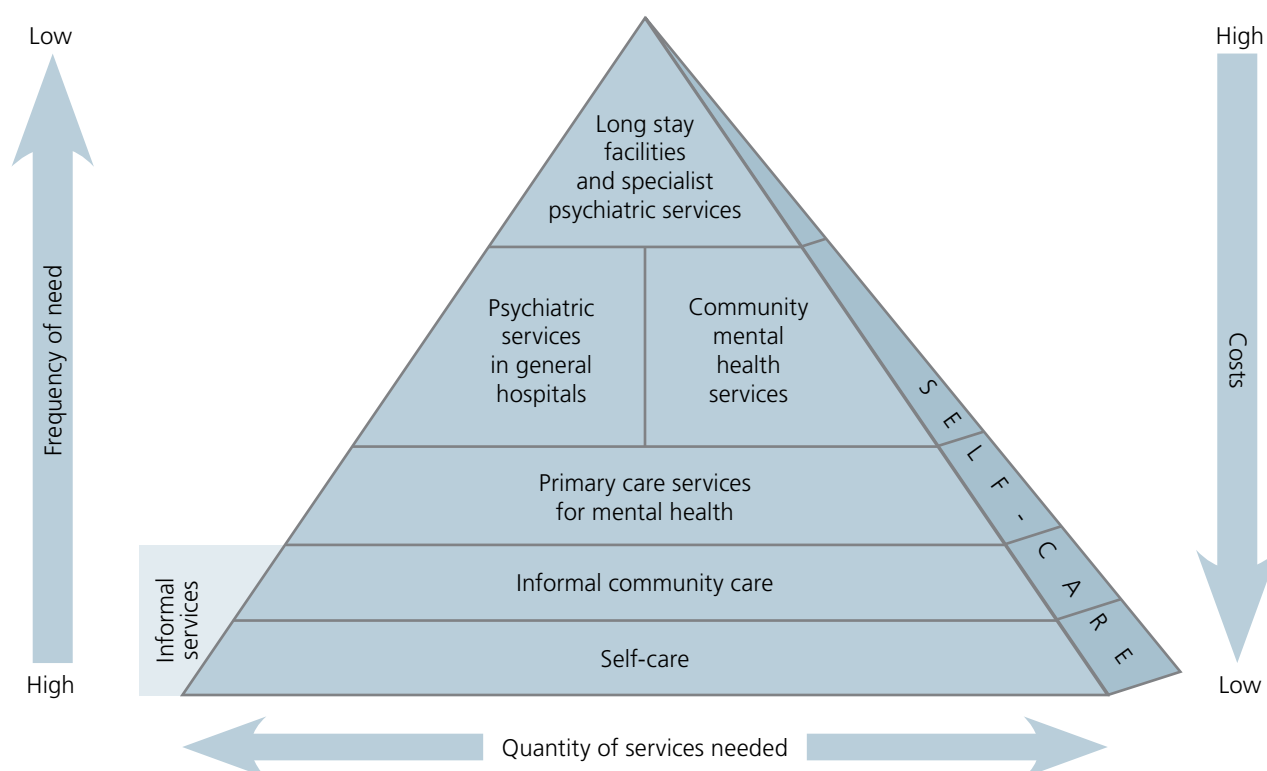
helps strengthen advocacy for systemic change. WHO has developed the Mental Health Policy and Service Guidance Package to help countries with this process (18).

Purpose of this report

Emergencies are ripe and important occasions for mental health reforms to be introduced. As stated previously, this is because attention and resources are turned towards the psychological welfare of affected people, while decision-makers become willing to consider options beyond the status quo. These conditions create possibilities to improve the lives of large numbers of people with mental disorders.

The possibilities presented by emergency situations are significant because major gaps remain worldwide in the realization of comprehensive, community-based mental health care. This is especially true in

Figure 2. The WHO Service Organization Pyramid for an Optimal Mix of Services for Mental Health (17)



low- and middle-income countries, where resources are scant and barriers are great (21, 22). Good progress has been made in some countries (20, 23), but too few are making major strides forward. Most countries still allocate their resources inefficiently, usually towards psychiatric hospitals (24). Mental health systems of most low- and middle-income countries tend to remain mired in the status quo, because political will for systemic change has often been absent (22).

By publishing this report, WHO aims to ensure that countries faced with emergencies will not miss the chance to use available political will for change and to initiate mental health reform. Global progress on mental health reform would happen more quickly if, in every major crisis, strategic efforts were made to convert short-term interest in mental health problems into momentum for mental health system development.

The 10 cases that form the core of this report (see Box 1) provide proof of concept and demonstrate clearly that it is possible to make systemic change. These experiences do not comprise an exhaustive review: despite the exceptional nature of this work, a number of other countries have also achieved successful mental health reform during or following emergencies. All cases featured in this report were initiated between 2000 and 2010 and were chosen partly because they have succeeded in making clear improvements in people's access to mental health services in the community. These cases are largely unknown to those working in international health and emergency relief and recovery, yet are important illustrations of how it is possible to take proactive action amidst emergencies to build back better (25) to achieve the goal of improving the mental health and functioning of people affected by emergencies.

Box 1. Summary of the 10 cases featured in this report

Afghanistan: Following the fall of the Taliban government in 2001, mental health services received increased attention. Despite the country's complex and fragile context, remarkable progress has been made in coverage. Mental health has been declared a priority health issue and has been included in the country's Basic Package of Health Services.

Burundi: Modern mental health services were almost non-existent prior to the past decade. Concerted efforts, led initially by a nongovernmental organization (NGO) and later by the government, have contributed to reform. Today, the government supplies essential psychiatric medications through its national drug distribution centre, and outpatient mental health clinics are established in several provincial hospitals.

Indonesia (Aceh): In a matter of years following the tsunami of 2004, Aceh's mental health services were transformed from a single mental hospital to a basic but functioning system of care, grounded by primary health services and supported by secondary care offered through district general hospitals. It is now viewed as a model for other provinces in Indonesia.

Iraq: Reform of mental health care has been ongoing in Iraq since 2004. Despite violence and instability, significant progress has been made to create the structure of a comprehensive mental health system throughout the country. Community mental health units now function within general hospitals, and benefit from more stable financial resources, human resources, and availability of essential medications.

Jordan: The influx of displaced Iraqi people into Jordan drew substantial support from donors and aid agencies. Within this context, community-based mental health care for Iraqi and Jordanian people was initiated. The project's many achievements built momentum for broader change across the country; service reforms and development are under way at all levels of mental health care.

Kosovo: After the conflict, rapid political change generated an opportunity to reform Kosovo's mental health system. A mental health taskforce created a new strategic plan to guide and coordinate efforts. Today, each of Kosovo's seven regions offers a range of community-based mental health services.

Somalia: The governance structure in Somalia has been in disorder for more than 20 years, and during most of that time the country has been riddled with conflict and humanitarian emergencies. This case demonstrates that important improvements in mental health services can be achieved in contexts where national governance for instituting national reform is lacking.

Sri Lanka: The country was able to capitalize on attention directed to mental health in the aftermath of the 2004 tsunami. It has made rapid progress in the development of basic mental health services, extending beyond the tsunami-affected zones to most parts of the country. A new national mental health policy is guiding the development of decentralized and community-based care.

Timor-Leste: Prior to the humanitarian emergency of 1999, there were no mental health specialist services in the country. Today, the Timor-Leste National Mental Health Strategy is part of the Ministry of Health's overall long-term strategic plan. Mental health services are organized across the different levels of the health system.

West Bank and Gaza Strip: Following the start of the second intifada, the momentum generated by humanitarian relief efforts was channelled into longer-term mental health reform in the West Bank and Gaza Strip. Significant improvements in the mental health system have been made over the past decade, towards community-based care and integration of mental health into primary care.



Haiti. © Nancy Palus/IRIN.

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Part 2.

Seizing Opportunity in Crisis: 10 Case Examples

Part 2 of this report provides detailed information on how health systems have seized opportunities during and after crises to build better mental health care. The 10 case examples represent a wide

range of emergency situations, as well as political contexts. Important practices and lessons learnt in how to achieve success are highlighted within each case.



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Afghanistan. © Kate Holt/IRIN. Reprinted with permission.

Afghanistan

Summary

Afghanistan has experienced protracted violence and instability for the past 30 years. Following the fall of the Taliban government in 2001, attention increased on strengthening mental health services in the country. Initially, nongovernmental organizations (NGOs) took the lead in implementing services. From 2004, the Ministry of Public Health became increasingly involved, and in 2010 it endorsed a five-year National Mental Health Strategy. Although Afghanistan is one of Asia's poorest countries, humanitarian recovery programming has paradoxically resulted in one of the continent's most successful experiences in integrating and scaling up mental health care in selected areas of a country. Significant challenges remain, but important progress has been made in raising the priority of mental health care and providing services to those in need.

Background and context

Afghanistan is a central Asian country that has been plagued for decades by violent conflict and political instability. From the Soviet invasion in 1979, to the civil war in the 1990s, to the rise of the Taliban and their fall from power in 2001, Afghans have been subjected to harsh rule and massive human rights violations. After 2001, the situation in the country seemed to stabilize, but in recent years violence has once again increased. Government officials, schools, NGOs, and United Nations agencies have been targeted. Displacement has put additional strains on the country: more than five million refugees have returned to Afghanistan since 2002, increasing the population by more than 20%. In 2011, three million Afghan refugees were still residing in neighbouring countries, while 350 000 were internally displaced within the country.

There has been no nationwide study of the mental health situation, but surveys indicate consistently high levels of mental distress in the Afghan population. According to the United Nations Office on

Drugs and Crime, opiate-related substance use disorders have been on the rise since 2000.

Mental health services in Afghanistan have been limited and strongly hospital-based, consisting of a few departments of neuropsychiatry in university hospitals and a national mental hospital in the capital city, Kabul. These services have been strongly oriented to pharmacotherapy. Services for substance use disorders (opiates in particular) have been limited in number and quality. Traditionally, people with mental disorders have sought help from traditional healers in their communities.

In the 1980s, the Ministry of Public Health (MOPH) began decentralizing mental health care and developing community mental health services. This resulted in the establishment of four community mental health centres in Kabul; the process was halted in other parts of the country by the growing civil war. In 1999, the World Health Organization (WHO) Regional Office for the Eastern Mediterranean organized a comprehensive 3-month diploma

course in northern Afghanistan to train 20 doctors in psychiatry. Because of ongoing violence, however, this initiative could not be continued. By 2001, much of the qualified workforce and technical expertise had left Afghanistan. The country, with an estimated 25 million people at that time, had just two qualified psychiatrists (neither of them working in mental health service delivery) and around 138 other health-care staff (general doctors and nurses) providing mental health services. There was no regular budget allocation for mental health services. Small inpatient facilities for people with mental disorders existed in a few large cities.

Turning the emergency into an opportunity to build back better

After the fall of the Taliban government, the new government decided to contract NGOs to provide health services. Meanwhile, the MOPH concentrated on regulation and policy-making. The core health services to be delivered were described in the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS). These documents identified the minimum package of interventions to be provided by the various levels of the health-care system.

The initial version of the BPHS (2003) included mental health among its seven priority areas. This was due to advocacy by WHO and NGO representatives, and also because the MOPH had an interest in mental health issues, as is common in countries affected by war. Many senior officials declared that the mental health of the Afghan people had suffered greatly.

Despite the government's interest, the 2003 version of the BPHS relegated mental health issues to a second-tier priority. This meant that funds would

not be allocated to mental health services, with the justification that “while mental health and disabilities deserve the attention of the health sector because they are significant causes of morbidity, they do make a smaller contribution to reduction of preventable mortality in comparison with other elements of the BPHS”.

From 2004, the MOPH took a stronger stand. This was due mainly to the commitment of the new Minister of Public Health, who declared publicly that mental health issues were among his most urgent priorities. A strategy paper for the integration of mental health into primary health care was adopted in 2004, and several NGOs developed mental health training materials for general health workers. The 2005 version of the BPHS included mental health in its first tier of priorities.

Progress to date

For five years following the fall of the Taliban government, mental health service development was driven to a large extent by NGO projects, which aimed to integrate mental health into general health services.

In the eastern province of Nangarhar, the NGO HealthNet TPO integrated mental health services into all health facilities, thereby providing coverage to almost 1.4 million people. Staff working in basic health facilities were trained in mental health and then provided with regular supervision. District hospitals in the province began to offer outpatient services, and a mental health ward was established in the provincial hospital. In Nangarhar province alone, 334 doctors, 275 nurses and midwives, and 931 community health workers received basic mental health training (see Photos 1 and 2). During the first

six years of the programme, a total of 23 doctors were trained as trainers. The proportion of mental health consultations in general care increased in nine years from less than 1% to around 5% (95 058 people diagnosed and treated; see Figure 1).

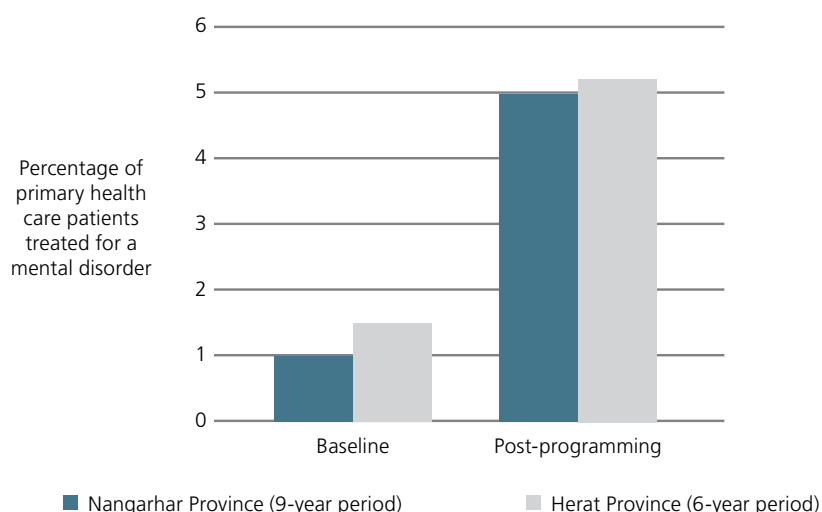
In the Western province of Herat, the NGO International Assistance Mission developed community mental health services. A mental health training centre was opened, and all health-care professionals (doctors, nurses, and midwives) working in primary health care in the Western provinces began to receive training. As in Nangarhar, this led to more people with mental disorders being identified in primary care. The proportion of primary care patients in Herat diagnosed and treated for a mental disorder rose from 1.5% in 2005 to 5.2% in 2011 (see Figure 1).

In Kabul, Caritas Germany established 10 counselling centres. These centres were later handed over to two local NGOs. In total, they assisted more than 11 000 clients, 70% of whom reported significant improvements. Based on these experiences and fur-

ther pilots within public health facilities, counselling was included in the BPHS.

These rather disconnected NGO initiatives became more integrated when the MOPH took a stronger role in policy development and service coordination. Essential to this process was the involvement of a few dedicated Afghan mental health professionals, such as one Afghan psychiatrist who acted as WHO mental health advisor and who was a key advisor to the MOPH. In 2005, the MOPH re-established a department for mental health and drug demand reduction; this department benefited from the long-term secondment by the European Community (EC) of an expatriate mental health advisor. In 2008, a technical working group of the Ministry, WHO, and NGOs produced a full range of mental health training manuals for different health worker cadres (doctors, nurses and midwives, community health workers). Furthermore, a new category of health worker was introduced: the psychosocial counsellor. These paraprofessionals participated in a 3-month classroom training followed by a 9-month supervised practice in a health facility as part of their education.

Figure 1. Improvements in diagnosis and treatment rates following integration of mental health into general health services



The 2010 revision of the BPHS further strengthened mental health services in outpatient settings. It called for psychosocial counsellors to be added to health centres, and basic mental health training for medical doctors working with them. Additionally, the BPHS revision called for a mental health focal point in each district hospital. Eight mental health indicators became part of the national health information system. Key psychiatric medications were introduced into the Afghan essential drug list.

In 2010, a 5-year National Mental Health Strategy was endorsed by the MOPH. This strategy aims to have mental health services in 75% of all health facilities by 2014.

The EPHS is now being revised, with greater attention to mental health services within provincial and regional general hospitals. Meanwhile, the psychiatric hospital in Kabul re-opened in 2004 and now has 100 beds and a unit for the treatment of substance use disorders. A current EC-funded project, implemented by the International Medical Corps, is focused on improving the quality of services in the hospital and developing it as a training centre.

Overcoming ongoing challenges

Establishing a mental health system posed significant challenges in the complex and fragile context of Afghanistan. Ongoing and worsening security problems interfered with field supervision



Photo 1. Two midwives interviewing a community member as part of their mental health training.
Photo: Peter Ventevogel. Reprinted with permission.

and training. Other challenges were more specific to mental health, such as the concern that while training medical staff can result in successful assessment and management of mental disorders, it can also lead to potential over-diagnosis of disorders and overuse of psychiatric medications. The addition of psychosocial counselling services within general health services has helped reduce this potential problem.

Financial sustainability of mental health services is an ongoing challenge. Afghanistan's health sector is heavily dependent on international donors and, as such, is subject to varying priorities and timelines. Future levels of international health funding are unclear. Even if funds continue at current levels, health

workers are often overburdened and have limited time to address the mental health needs of their patients. However, the MOPH remains strongly committed to the integration of mental health services into primary health care and actively encourages donors to invest in mental health service delivery by paying for the retraining of all health staff and creating new positions for psychosocial counsellors.

More generally, progress is still needed in a number of areas. Mental health issues require more attention in health workers' pre-service educational curricula. Funding and services for those with substance use disorders need better integration with other mental health care. Services for children and adolescents are lacking and require development.



Photo 2. Training village health volunteers in Nangarhar Province, where 95 058 people were assessed and managed in primary health care clinics. Photo: Peter Ventevogel. Reprinted with permission.

Given the enormous challenges that Afghanistan has faced, mental health services have improved remarkably in the decade since the fall of the Taliban government. Afghanistan has substantial experience in

scaling up the integration of basic mental health care into the general health system, and can serve as an inspiring example for other post-conflict countries.

Lessons learnt

- Ministry of Health leadership is important. Afghanistan's mental health system has benefited from the personal commitment of the current and former Ministers of Public Health.
- The adoption of a National Mental Health Strategy and the inclusion of mental health in general health policy documents and health service delivery guidelines are essential to ensure that mental health becomes a matter for all health workers, not only for specialists.
- Coordination between government, donors, and NGOs is important to ensure harmonized service delivery.
- Training general health workers in basic psychiatry should be accompanied by psychological and social interventions, such as psychosocial counselling and community-based psychosocial interventions.
- Clinical supervision is essential to emphasize and facilitate the use of non-pharmacological approaches to common mental disorders.

Contributors

Peter Ventevogel, Mental Health Advisor, HealthNet TPO (Amsterdam). From 2002 to 2005, Programme Manager for Mental Health in Afghanistan, HealthNet TPO

Bashir Ahmad Sarwari, Acting Director, Mental Health and Drug Demand Reduction, Ministry of Public Health, Afghanistan

Inge Missmahl, Director, International Psychosocial Organisation (IPSO). Since 2004, leading the development of IPSO psychosocial counselling in Afghanistan with her Afghan team. From 2008 to 2010, Technical Advisor for Mental Health, Ministry of Public Health, Afghanistan

Hafiz Faiz, Project Coordinator, Mental Health Programme in Afghanistan, International Medical Corps. Previously, Programme Manager for Mental Health in Afghanistan, HealthNet TPO

Heini Mäkilä, Support Director for Health, International Assistance Mission, Herat, Afghanistan

Fareshta Queedes, Project Manager, Master Trainer for Psychosocial Counselling, IPSO International Psychosocial Organisation

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Burundi. Photo: © Peter Ventevogel. Reprinted with permission.

Burundi

Summary

An international nongovernmental organization (NGO) started providing mental health services in Burundi during the year 2000. At that time, the country was transitioning from civil war. Mental health services were established, covering large parts of the country. In 2005, following the formal restoration of peace, the NGO (now named HealthNet TPO) shifted its activities from delivering direct services to building the capacity of Burundi's new government to provide mental health services as part of its overall health system. The handover of mental health services has presented formidable challenges arising from difficulties in financially sustaining mental health services. Nonetheless, progress has been made in several areas.

Background and context

Burundi is a small, densely populated country situated in the African Great Lakes region. The country has experienced cyclical outbreaks of violence. In 1993, the assassination of the president was followed by widespread massacres and a civil war that ended with a peace agreement in 2001, and the restoration of democracy in 2005. An estimated 400 000 Burundians have been killed in the past few decades. Some 800 000 were forced to flee to neighbouring countries, and hundreds of thousands were internally displaced. The proportion of the population living below the poverty line rose from 58% in 1993 to 89% in 2002.

Very little is known about the prevalence of different mental disorders in Burundi. Prolonged warfare and conflict are believed to have led to a range of social and mental health problems for at least some of the population. In addition, epilepsy, a neurological disorder that is often managed in mental health clinics, is thought to be particularly prevalent due to a high rate of complications of childbirth and infections that can affect brain functioning.

Modern mental health services were almost non-existent prior to the past decade. In 2000, the Ministry of Public Health (MOPH) did not have a mental health unit or a mental health policy or plan. The entire country had just one psychiatrist, and altogether lacked psychiatric nurses and psychiatric social workers. Virtually all mental health services were provided by a single psychiatric hospital that was run by a Catholic congregation. This hospital had limited capacity, with around 60 beds and an outpatient service, and was frequented mainly by people living near the capital, Bujumbura. Given this dearth of services, Burundians relied heavily on informal practices to deal with mental health issues. Severe mental disorders were commonly believed to be due to spirit possession or to war experiences.

Turning the emergency into an opportunity to build back better

The NGO Transcultural Psychosocial Organization (TPO; later called HealthNet TPO) initiated psychosocial and mental health activities at the request of Burundians, who had visited its project in Uganda.

A needs assessment was conducted in 1998 and results were used to build consensus for action among Burundian authorities, United Nations agencies, and other NGOs. In 2000, a pilot project – financed by humanitarian aid funds – was initiated in Bujumbura and surrounding provinces. It was felt that mental health services would be crucial for empowering and reintegrating war survivors in post-conflict societies.

The project started under fragile financial conditions. The majority of its funding came from a single donor, the Dutch government. The MOPH originally agreed to provide the psychotropic medications for the project but was initially unable to fulfil this commitment.

Additional obstacles were more conceptual in nature: the project challenged traditional ways of understanding and providing mental health care in the country. Health professionals familiar with community-based mental health care, who could potentially serve as policy developers, trainers, or supervisors, were generally lacking. Existing leaders from the psychiatric hospital initially opposed the provision of community-based services, but later became active collaborators with the project.

In its first years, the programme built a network of psychosocial and mental health services in communities in Bujumbura and in seven (41 %) of the country's 17 provinces.

A new health worker cadre, the psychosocial worker, was introduced and salaried by the project. People with prior experience as social workers, teachers, nurses, or community development workers were selected for this role. They initially received six weeks of classroom training, followed by two weeks

of field training. Ongoing supervision was provided once they were deployed; psychosocial workers met weekly as a group with their supervisors to discuss new or difficult cases. This format enabled them to improve their skills through sharing of experiences and collective learning. In time, they developed the necessary basic skills to manage a wide range of mental health issues (see Photo 1). They provided a broad package of psychosocial services to individuals, their families, and their communities. All psychosocial workers were provided with a motorbike, which enabled them to cover two or three municipalities.

More specialized psychiatric services, including medication and psycho-education, were provided through monthly mental health clinics held in provincial hospitals (see Photo 2). A team consisting of an expatriate psychiatrist and Burundian nurses employed by the NGO ran these clinics. They saw people referred by the psychosocial workers or health-care professionals, and those who self-referred. Given the absence of qualified psychiatric nurses in Burundi, the NGO paid for the three-year psychiatric nursing training of two Burundian nurses in Rwanda.



Photo 1. Psychosocial worker assisting boy with epilepsy and his father, 2005.

Photo: Peter Ventevogel. Reprinted with permission.



Photo 2. People queuing for mental health outpatient clinic in provincial hospital of Muyinga, 2006.

Photo: Peter Ventevogel. Reprinted with permission.

In 2005, a democratically elected president took office and peace returned to the country; this political change allowed HealthNet TPO to begin to advocate for the anchoring of mental health services within government-run health-care structures. Together with the MOPH, it organized two international conferences in Bujumbura (in 2006 and 2008) to discuss the integration of mental health within general health care.

In 11 (65%) of the 17 provincial hospitals, mental health care was integrated into general health services through the establishment of outpatient mental health clinics. Four government nurses from each provincial hospital received mental health training, which was provided by an expatriate psychiatrist and a Burundian nurse. Each nurse received a 20-day basic training, a 5-day clinical internship, and a 5-day refresher course. The physicians working at the provincial hospitals received a 5-day introductory training and follow-up. All courses were part of the government's plan to decentralize mental health services and integrate them into general health care. HealthNet TPO provided technical assistance, supervision, psychotropic drugs, and adaptation of the health information system.

Meanwhile, the psychosocial workers grew into effective agents for advocacy and change. Initially, they provided mainly direct psychosocial assistance and referral services. As their roles developed, they also started training and coaching community-based organizations.

A national mental health strategy was drafted and signed by the Minister of Public Health, and a national mental health policy was drafted in 2007 by a multidisciplinary team with representatives of the MOPH, the World Health Organization (WHO), and HealthNet TPO. Monitoring and reporting tools have been elaborated by the project, and six psychiatric diagnoses have been incorporated into the government's health information system (epilepsy, schizophrenia, other psychosis, post-traumatic stress disorder (PTSD), depression and anxiety, and substance use disorders, including alcohol use disorders). Following ongoing advocacy by HealthNet TPO, the National List of Essential Drugs has been revised and now includes all basic psychotropic and anti-epileptic drugs from the model List of Essential Drugs by WHO, with the exception of long-acting depot medication, which was deemed too costly. As with all other medications, patients must pay out-of-pocket for medications unless they are younger than five years old or are pregnant.

Progress to date

Since 2003, the project has maintained a database recording the number of people who have requested assistance from psychosocial workers. In total, 17 713 people have been assisted. They requested assistance for (severe) mental disorders (21.5%), for epilepsy (35.1%), and for psychosocial problems unrelated to these conditions (43.4%; see Table 1). People in this latter group – those with psychosocial problems who did not have a mental disorder or epilepsy – generally required greater involvement by psychosocial workers. Family disputes, depression, bereavement, or suicidal behaviour, and socio-economic and health-related complaints were the most frequent problems among this group (see Table 2).

From 2006 to 2008, the mental health clinics in the provincial hospitals registered almost 10 000 people, who received more than 60 000 consultations (see Table 3). The majority (65%) were people with epilepsy.

In 2011, funding from the Dutch government enabled HealthNet TPO and the Burundian government to initiate a 5-year project aimed at strengthening health systems. One of the project's components is the integration of mental health care into primary

care. The project is using the WHO mhGAP Intervention Guide (see related publications list) for treating mental disorders in non-specialist health settings. The first steps have been completed: the establishment of a national commission, a needs assessment, and identification of priority mental disorders. A pilot programme will soon be implemented in Gitega province. Primary care services will be supported by mental health care in general hospitals and follow-up within the community.

Overcoming ongoing challenges

The transition of mental health services from the NGO to the governmental health authorities, which occurred from 2007 to 2010, presented formidable challenges. It proved to be difficult for the Burundian health authorities to sustain their plans to provide mental health services. The government was faced with severe funding problems, and political instability hampered its decision-making. Public institutions were rebuilt, but challenges remained within governmental services.

The approval of the mental health strategy has not yet led to structurally increased government fund-

Table 1. Number of unique clients* seen by psychosocial workers, 2000–2008

Type of consultation	Number of clients	Percentage
Mental disorder	3803	21.5%
Epilepsy	6215	35.1%
Psychosocial problem	7695	43.4%
Total	17 713	100%

* Many clients were seen multiple times over the reported time period.

ing for mental health care. The budget for mental health services remains around US\$ 55 000, or 0.43% of the total health budget. More than 90% of this very small budget is allocated to the country's main psychiatric hospital and covers its staff salaries. Patients in the clinics established by HealthNet TPO were asked to pay 1000 Burundian Francs (around 0.6 Euros in 2011) per consultation. For many peo-

ple with chronic mental disorders or epilepsy, however, this modest contribution was a major barrier.

Nonetheless, much progress has been made. The government is now supplying essential psychiatric medications through its national drug distribution centre. Most outpatient mental health clinics at provincial hospitals continue to serve people in need.

Table 2. Types of psychosocial problem* seen by psychosocial workers, 2001–2008

Type of problem	Percentage of total contacts (n = 7695)
Family disputes	20.8%
Suicidal behaviour/depression/bereavement	13.1%
Socioeconomic complaints	8.1%
Complaints related to general health	8.1%
Sexual violence/rape	7.2%
Child abuse and other related problems	5.9%
Psycho-trauma	5.9%
Domestic violence	4.3%
Stress and psychosomatic complaints	4.1%
Human rights violations/legal problems	3.8%
Sexual/reproductive problems	3.6%
Psychosocial problems related to HIV/AIDS	3.2%
Intellectual disability	2.2%
Spirit possession	1.0%
Alcohol/drug use problems	1.6%
Community relations	1.5%
Other problems	5.6%
Total	100.0%

* Clients with a severe mental disorder or epilepsy are not included.

Lessons learnt

- Providing mental health services at the level of the provincial hospital is an important first step.
- Availability of provincial hospital-based care should be followed by integration of mental health services at the health centre level. This would make mental health services accessible to all. It is likely that many people with less severe mental disorders, such as mild or moderate depression or anxiety disorders, will not visit a specialized mental health centre, but might present to the general health care system if mental health services were available there.
- Although the provinces in Burundi are small and the provincial hospitals can be reached within a half-day on foot by almost everyone, it is not realistic to expect people with chronic disorders to seek treatment on a monthly basis if centres are far from their homes.
- Activities to increase involvement of the health authorities are critical – particularly to pay staff salaries and to provide essential psychiatric medications.

Table 3. Problems among users of provincial mental health clinics, 2006–2008

	Number of people	%	Number of consultations
Epilepsy and other neurological problems			
Generalized epilepsy	6289	64%	43 074
Other neurological problems	89	1%	402
Subtotal	6378	65%	43 476
Psychotic disorders			
Schizophrenia	632	6%	5584
Other psychoses	1725	18%	8598
Bipolar disorder	104	1%	446
Subtotal	2461	25%	14 628
Other mental disorders			
Depression	704	7%	2750
Substance abuse	21	1%	38
Behavioural problems	65	1%	253
Other, e.g. stress, anxiety	188	2%	532
Subtotal	978	10%	3573
Total	9817	100%	61 677

Contributors

Peter Ventevogel, psychiatrist and medical anthropologist, technical advisor for Mental Health, HealthNet TPO. From 2005 to 2007 he was based in Burundi

Herman Ndayisaba, clinical psychologist, has performed various functions with the programme in Burundi since 2000; since 2005, country representative for Burundi, HealthNet TPO

Willem van de Put, medical anthropologist, general director, HealthNet TPO

Nancy Baron, psychologist, involved in establishing the programme in Burundi in 2000. Currently Director, Global Psycho-Social Initiatives and Psycho-Social Services and Training Institute, Cairo, Egypt

Joop de Jong, Professor of Cultural and International Psychiatry, University of Amsterdam, Boston University, and Rhodes University. Founder, TPO (Trans-cultural Psychosocial Organisation)

Jérôme Ndaruhutse, National Professional Officer/ Disease Prevention and Control, WHO Burundi

Jocelyne Miburu, Head of Mental Health, Ministry of Public Health, Burundi

Wilma Meeus, Public Health Advisor, HealthNet TPO

Sonali Sharma, Mental Health Advisor, HealthNet TPO

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Aceh, Indonesia. Photo: © UNHCR/J. Perugia. Reprinted with permission.

Indonesia (Aceh)

Summary

The province of Aceh in Indonesia suffered from decades of civil strife before it was struck by the devastating tsunami of 2004. Hundreds of thousands of people were killed or displaced, creating substantial mental health needs in the population, as well as high levels of donor interest and support. Following the immediate aftermath of the emergency, health officials decided to focus on strengthening the province's mental health system. In a matter of years, Aceh's mental health services were transformed from a single mental hospital to a basic but functioning system of care, grounded by primary health services and supported by secondary care offered through district general hospitals. Aceh is now viewed as a model for other provinces in Indonesia that are seeking to improve their mental health services.

Background and context

Aceh is a province of Indonesia located on the Island of Sumatra. It forms the most northern and western part of the Indonesian archipelago between the Straits of Malacca and the Indian Ocean. Its population of roughly 4.5 million people is distributed across 23 districts and municipalities.

Aceh suffered from more than 30 years of conflict between the Free Aceh Movement and the Indonesian military. According to official estimates, more than 30 000 people died as a result. A peace agreement on 15 August 2005 ended this long conflict.

In 2004, prior to the peace agreement, Aceh experienced catastrophe when it was hit by the worst tsunami in recorded human history. While estimates vary, around 165 000 people are presumed to have died in Aceh alone, and close to 400 000 people were displaced as a result of the tsunami. Of the province's 244 health facilities, 53 were destroyed or severely incapacitated. Photo 1 provides a glimpse of the devastation to the province's infrastructure.

Before the tsunami struck, mental health care was available only through the province's sole mental hospital, located in the capital city of Banda Aceh. This mental hospital was institutional in nature, with one part-time and two full-time psychiatrists, 220 beds, and an occupancy rate usually exceeding 100%. Meanwhile, primary and secondary health centres had very limited to non-existent capacity to deliver mental health services. To complicate matters, those who managed to find mental health services were required to pay out-of-pocket for their care.

Turning the emergency into an opportunity to build back better

In the aftermath of the tsunami, more than 100 Indonesian and international agencies arrived in Aceh to offer a wide range of mental health and psychosocial support services of diverse quality. In addition to providing acute support to tsunami survivors, their presence helped create awareness and demand within the population for community-based mental health care. The vast majority of agencies,

however, planned to stay only for the initial emergency period. After they left, their services and supports would no longer be available, and most had nothing planned to ensure that care would continue in the longer term.

As a result of this expected service gap, Indonesia's Ministry of Health (MOH) and the World Health Organization (WHO) provided leadership to develop sustainable community-based mental health services. Actions were based on WHO's (2005) *Recommendations for Mental Health in Aceh*, which included a specific recommendation on building a comprehensive mental health system.

One objective was to integrate mental health into the province's primary health care (PHC) system. Throughout Indonesia, PHC is an important and well-functioning part of the overall public health system. PHC services are delivered in public health centres (*puskesmas*), which are located throughout every sub-district in the country. District general hos-

pitals provide secondary care, and provincial general hospitals provide tertiary and specialized care.

To build consensus and commitment from major stakeholders, a mental health programme planning workshop was organized in Banda Aceh in May 2005. Participants included representatives from the MOH, the Aceh Provincial Health Office, the District Health Offices, WHO, universities, and nongovernmental organizations (NGOs) with longer-term commitments to work in Aceh. Participants agreed to work together to develop mental health services in PHC – using in part the work already developed and implemented by the International Medical Corps in one district – while improving the quality of care in the sole existing mental hospital, and later providing care in certain district general hospitals.

The programme would rely on community mental health nurses to deliver mental health care. Within this model, nurses would conduct home visits, ensure that people with mental disorders received ap-



Photo 1. Devastation in Aceh, Indonesia following the 2004 tsunami. Photo: Albert Maramis. Reprinted with permission.

appropriate medication, and provide support to families. When needed, they would refer people to acute inpatient care. A training module was developed with the Faculty of Nursing at the University of Indonesia. Three training levels – basic, intermediate, and advanced – were designed to teach nurses to provide care for people with severe mental disorders in the community, and at the more advanced levels to prevent mental disorders and promote mental health. (Photo 2 depicts trainee nurses about to make a round of home visits.) For medical officers, the MOH and the Department of Psychiatry's Faculty of Medicine at the University of Indonesia developed a short refresher course on primary care psychiatry.

Initially, training and supervision were implemented in the 11 most affected districts of Aceh. In each of these districts, 10 PHC centres were selected, each of which chose two nurses for training. A total of 110 PHC centres and 220 nurses participated. After completing their training, these nurses were responsible for providing mental health services in their communities.

Several international agencies participated in this effort. WHO supported the initial round of training. Later, the Asian Development Bank (ADB) and the United States Agency for International Development (USAID) joined to help develop these community-based mental health services. Another international organization, CBM, supported training for community-based mental health services in five districts of Aceh and donated motorcycles to be used by nurses for home visits (see Photo 2). CBM also collaborated with district health offices to develop sustainable PHC-based mental health services in these areas.

Parallel to this effort, reform was undertaken at the Banda Aceh Mental Hospital. The Norwegian Red Cross, ADB, and WHO advocated for open wards in place of locked wards, and a pilot project showed the potential of this approach. Steps were taken, albeit slowly, to embrace a specialist role for the hospital. The hospital management conducted short-term training programmes for its doctors and nurses. CBM supported the establishment of a fully equipped epilepsy clinic.



Photo 2. Mental health nurse trainees use motorcycles to make home visits in Aceh Barat. Motorcycles were donated by an NGO, CBM, while district health authorities provide fuel and maintenance.
Photo: Andrew Mohanraj. Reprinted with permission.

Meanwhile, the first psychiatric intensive care unit was established in Jantho General Hospital in the district of Aceh Besar. USAID supported construction and staff training, while ADB funded the development of training modules. This acute care unit now serves as a model in Indonesia for providing acute inpatient mental health care in a district general hospital. It delivers short-term care for people with severe mental disorders, who cannot be treated in the community due to the severity of their symptoms. The goal is to stabilize them and then refer them back to their PHC centre.

Two other inpatient units were established subsequently. With support from CBM, a unit was opened within the Cut Nyak Dien general hospital in Meulaboh, Aceh Barat, which serves the population living along the west coast of Aceh. Another inpatient unit was established by the local government in Takengon at Datu Beru Hospital, which covers the central region of Aceh. In both these units, health workers liaise closely with primary care services to discharge patients within the shortest possible timeframe, and to encourage family involvement in rehabilitation.

Progress to date

Significant progress has been made since the devastating tsunami struck Aceh in 2004. All districts in the province have at least some capacity to deliver mental health services at primary care level. At the secondary or district level, three district general hospitals are providing short-term hospitalization for acute exacerbations of symptoms of severe mental disorders, as well as outpatient services. At least three additional units are needed to cover the southwest, north, and east coasts of Aceh. At the tertiary or provincial level, the existing Banda Aceh Mental Hospital is improving its quality of care,

although progress is still needed to improve its overall conditions.

District health officials have demonstrated their commitment to mental health reform by allocating funds specifically for mental health programmes. Before the tsunami, none of Aceh's districts had specific mental health budgets. One year after the reform of mental health services started, five districts had taken this important step, and this trend has continued. For fiscal year 2011, 13 out of 23 districts/municipalities had specific mental health budgets. This is a key indicator of progress, because health services planning and resource allocation in Indonesia are decentralized to the district/municipality level.

In 2010, Aceh further demonstrated its commitment to improving services through the inclusion of mental health within its Provincial Regulations on Health (2010/4).

Aceh, which like many provinces in Indonesia had only tertiary care before the tsunami, is now the only province with a public mental health system moving towards comprehensive care at primary, secondary, and tertiary levels. While more needs to be done, including expanding secondary care services to underserved parts of the province and further reforming the tertiary mental hospital services, the groundwork has been laid. Regulatory support and funds allocated specifically for mental health in many districts will help reinforce progress to date. The configuration and functioning of Aceh's mental health system is an example for other provinces to follow.

Lessons learnt

- Coordination of relief efforts in the immediate aftermath of an emergency is essential but difficult; resources must be managed to ensure that they are distributed equitably and that service gaps are minimized.
- The influx of funds and resources following emergencies should be used not only to deliver short-term relief and support, but also to strengthen and develop the existing mental health system. The fact that secondary care mental health services are currently insufficient across all tsunami-affected areas of Aceh suggests that too many agencies and donors focused solely on short-term relief after the tsunami.
- Mental health services developed in one emergency-affected area of a large country can become the model for other areas of the country.

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Albert Maramis, NPO Mental Health & Tobacco Free Initiatives, WHO Country Office for Indonesia

Andrew Mohanraj, Country Director and Director of CBM/Aceh Psychosocial Rehabilitation Programme, CBM Indonesia

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Iraq. Photo: Ben Barber/USAID.

Iraq

Summary

Mental health reform has been ongoing in Iraq since 2004. At that time, a National Mental Health Council was established and, shortly thereafter, it developed a draft national strategy and plan. These were further refined and now serve as the basis for mental health reform in the country. Priorities include developing community mental health services, downsizing institutional psychiatric hospitals, developing acute care units in general hospitals, and integrating mental health care into primary health care. Despite ongoing violence and instability, significant progress has been made to create a community-based mental health system.

Background and context

Iraq's governmental and social infrastructure has been devastated by decades of dictatorship, the Iran–Iraq war, economic sanctions, the Gulf wars, the invasion in 2003, and the subsequent violent insurgency. Health-care delivery has suffered greatly.

Comprising more than 30 million people, the Iraqi population is relatively young (43% less than 15 years of age), urban (67%), and ethnically diverse. Around 80% are Arab; the second largest ethnic group is Kurdish. The population is predominantly Muslim.

Before 2003, mental health services were provided by fewer than 100 psychiatrists, who were providing (mostly outpatient) psychiatric services in a few general and university hospitals. In addition, there were two psychiatric hospitals in Baghdad (Al-Rashad, with 1325 beds, and Ibn Rushid, with 76 beds) and private clinics in the main cities for those who could afford them. No specific legislative protection existed for people with mental disorders. Obvious service gaps existed, such as child and adolescent psychiatry, geriatric psychiatry, and forensic psychi-

atry. Mental health services in rural areas were lacking, and integration of mental health services within primary health care was developing slowly with the assistance of the World Health Organization (WHO). Formal collaboration with departments or agencies outside the health system was rare.

During the past decade, the majority of Iraq's population has been subjected to threats of violence and death. By the end of 2007, about 1.6 million people were internally displaced (Photos 1 and 2)



Photo 1. This child, like many other Iraqis, was displaced to a refugee camp near the Syrian border.

Photo: © Phil Sands/IRIN. Reprinted with permission.

and an estimated 2.5 million were living as refugees in neighbouring countries (see accompanying case study of Jordan). Many Iraqis suffered from intense psychological distress as a result, and they – as well as others with longstanding mental health problems – were generally unable to access even the most basic mental health services and support.

Turning the emergency into an opportunity to build back better

In 2004, the Iraq National Mental Health Council (NMHC) was formed and developed an initial national strategy and action plan for mental health. This was a collaborative effort of the Ministry of Health (MOH), WHO, and other partners. One of the priorities identified in the action plan was the completion of a mental health assessment to better understand the strengths and gaps of the current mental health system.

In 2005 this assessment was completed, using the WHO-Assessment Instrument for Mental Health Systems (WHO-AIMS). The assessment's results highlighted a number of problem areas: the predominance of institutional psychiatric hospitals, insufficient mental health curricula in nursing and medical schools, vast shortages of trained health workers, restrictions on medication prescription authority, and lack of a comprehensive national mental health strategy.

These results were discussed at two subsequent action-planning conferences, which were convened by the NMHC and supported by the United States' Substance Abuse and Mental Health Services Administration (SAMHSA). The conferences brought together Iraqis from around the country along with foreign experts. They considered the earlier strategy and plan developed by the NMHC, as well as the more recent WHO-AIMS results, in an effort to de-



Photo 2. Men carrying emergency supplies in a refugee camp near Baghdad, Iraq.
Photo: © Contributor/IRIN. Reprinted with permission.

Table 1. Comparison of mental health services in Iraq prior to 2003 versus 2011

Mental health service level	Prior to 2003	2011
Long-stay facilities and specialist services	Two institutional-style mental hospitals in Baghdad.	Baghdad mental hospitals still exist; undergoing reform.
Psychiatric services in general hospitals	Outpatient services only, and limited to large hospitals in the centres of the governorates.	25 new mental health units, offering mix of inpatient and outpatient services. New inpatient beds for children and adolescents in paediatric hospital.
Community mental health services	Public outpatient services in major general and university hospitals. Private clinics in main cities for those who could afford them.	34 new outpatient-only units, including: <ul style="list-style-type: none">– 4 for children and adolescents;– 1 for maternal mental health;– 1 for geriatric mental health;– 8 for trauma counselling;– 1 for substance abuse rehabilitation and treatment.
Primary care services for mental health	Minimal.	Integration of mental services within PHC services has started throughout Iraq.

termine the most urgent priorities in rebuilding the country's mental health system.

One of the most important recommendations to come from these meetings was to create a mental health system that was radically different from the country's previous one. This included transforming the institutional, biomedically based model of mental health care to an integrated, community-based approach. Other recommendations that related specifically to the organization of mental health services were to integrate such services into primary health care; to establish rehabilitation programmes for people with severe mental disorders; to create substance abuse treatment programmes; to devel-

op specialty services for children, older adults, and forensic patients; and to liaise with leaders of major religious groups in the country. A number of recommendations were also developed for the content areas of policy and legislation, training and education, and research.

Progress to date

Since 2004, the NMHC has continued to meet and serve as an advisory board to the MOH. The NMHC is composed of representatives from different health sectors and related non-health institutions. These include the national adviser for mental health, mental health programme officers at the primary, second-

ary, and tertiary health care levels, and representatives from the programme of substance abuse, the Ministry of Justice, Ministry of Higher Education, Ministry of Interior, Ministry of Education, Ministry of Labour and Social Affairs, and Ministry of Human Rights. The main tasks of the NMHC are mental health planning, advising the government on mental health policy and legislation, managing and coordinating mental health services, and monitoring and assessing mental health initiatives throughout Iraq.

Mental health offices have been established in all governorates except Kurdistan. These offices work closely with the NMHC. Recently, Kurdistan has also established a mental health system, which parallels that of the national-level government system.

Iraq's mental health policy was first revised in 2004, and the current strategy and action plan cover the period 2009–2013. Priorities include developing community mental health services, downsizing institutional psychiatric hospitals, developing acute care units in general hospitals, and integrating mental health care into primary health care. The strategy and plan also address mental health advocacy and promotion, the protection and promotion of the human rights of mental health users, equitable access to mental health services across different groups, better financing, and the strengthening of monitoring and quality improvement systems.

Complementary to the WHO-AIMS assessment of 2005, which examined the country's mental health system, the Iraq Mental Health Survey of 2006/2007 assessed mental health problems in the Iraqi population. This was a nationally representative survey and used internationally accepted methodology with extensive quality controls. It produced data on the prevalence of different mental disorders and partic-

ularly affected groups, and also built the capacity of Iraqi professionals to conduct research and surveys.

At the level of service development, important steps were taken from 2009 to 2011 to integrate mental health services within the primary health care system. Administratively, a special section for primary mental health care was established within the MOH; similar primary mental care units were established within the health directorates of all governorates, and Kurdistan established a similar system within its governance structure. Training of local trainers was undertaken, and the national manual for primary mental health care was revised and updated. Subsequently, local training workshops were organized for primary care physicians, nurses, and other health workers in all governorates of Iraq, including Kurdistan. To complement this effort, a national formulary of psychotropic drugs was approved for use by primary care physicians participating in the workshops.

More generally, a range of courses, workshops, and resource materials for health workers on mental health issues have been developed and implemented. Around 80–85% of psychiatrists, more than 50% of general practitioners, and 20–30% of nurses, psychologists, and social workers in Iraq have received this training. School mental health programmes have also been established. Nonetheless, these efforts face difficulties such as shortages of buildings, physicians, psychologists, social workers, and medications.

To further facilitate the provision of community-based mental health care, community-based psychiatric facilities in general hospitals have been rehabilitated or built new. These facilities offer a mix of outpatient and inpatient services in a manner that aims to minimize stigma and maximize ease of ac-

cess. A total of 25 new community-based units in general hospitals are now functioning across Iraq.

An additional 34 outpatient-only mental health facilities are also providing services. These units are found mainly in general hospitals and primary health centres. Several are specialized for children and adolescents; one focuses exclusively on maternal mental health; and another is dedicated to geriatric mental health care. Yet other outpatient centres focus on narrower issues such as trauma counselling or substance abuse rehabilitation and treatment. These and other changes in mental health services are summarized in Table 1.

Meanwhile, efforts have been made to reform the psychiatric institutions that dominated mental health care in Iraq prior to 2003. In particular, Al-Rashad hospital has decreased its average number of residents by around 45 people, while taking steps to reinforce the number of health workers and improve the quality of its services. Slowly, the hospital

is redefining itself as a place where people with severe mental disorders can receive proper rehabilitation in a context where their human rights are upheld.

Overcoming ongoing challenges

The Iraqi MOH has worked to implement the recommendations of the planning conferences, but progress has been hampered in various ways. The violence and lack of security in many parts of Iraq have undermined the ministry's ability to implement service reform in certain geographic areas and have challenged the continuity of mental health reform. The lack of continuous financial support for mental health reform has been another issue. Nonetheless, following a concerted effort by the NMHC and WHO, several donors have stepped forward to support mental health development activities and projects in Iraq. These include the Government of Japan, the European Commission, and the World Bank. Influenced by these efforts, the Iraqi government has also started to allocate more of its own budget to mental health.

Lessons learnt

- Iraqi professionals living in the country and abroad provided essential support to establish the new mental health system.
- Both short-term and long-term plans were vital components of mental health reform.
- Establishing the National Mental Health Council and appointing well-qualified mental health advisers were key to ensuring the sustainability of mental health reform.
- Even in the midst of crises, it is important to make mental health services available at all levels of the health system.
- Projects and initiatives supported by NGOs and humanitarian funders can serve the national plan.

Contributors (alphabetical)

Emad Abdulrazaq, National Adviser for Mental Health, Ministry of Health, Iraq

Ayad Nouri Fattah, Director, Mental Health in Primary Health Care, Ministry of Health, Iraq

Manhal Helasa, Technical Officer, World Health Organization, Iraq Office in Amman

Aqila Noori, Medical Officer, World Health Organization, Iraq Office in Amman

Nezar Ismet Taib, Child & Adolescent Psychiatrist, Manager of Mental Health Centre, Duhok, Kurdistan region, Iraq

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Jordan

Summary

An influx of displaced, war-affected Iraqis into Jordan has drawn substantial mental health support from aid agencies and short-term humanitarian funds from donors. Within this context, the Ministry of Health of Jordan and the World Health Organization (WHO) initiated a pilot project to provide community-based mental health care to Iraqis and Jordanians. The project's many achievements built momentum for further change. A multisectoral policy development process was undertaken, resulting in Jordan's first ever national mental health policy. A new Mental Health Unit has been established within the Ministry of Health to lead the governance of the mental health field. Service reforms and development are under way at all levels of mental health care.

Background and context

The Hashemite Kingdom of Jordan has a population of 6.5 million people. Jordanians are predominantly young, urban, Arab (98%), and Muslim (92%). Jordan has been among the safest and most stable countries in the region. Over the past decades, it has periodically received influxes of refugees fleeing neighbouring countries. The United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) estimates that 1.9 million Palestinian refugees live in Jordan. Continuous waves of displaced Iraqis have flowed into the country since 2003. A Norwegian research institute, FAFO, estimated that 500 000 displaced Iraqis were residing in Jordan in 2007.

The influx of Iraqis in Jordan differs from other refugee situations because they do not live in defined camps; rather, they are scattered throughout the country, especially in major cities. Consequently, they are difficult to identify and reach with psychosocial and other services. A 2008 household survey conducted jointly by WHO, UNICEF, and Johns Hopkins University identified high rates of depressive

symptoms, fatigue, insomnia, and anxiety among displaced Iraqis. Experiences of conflict and interpersonal violence have contributed to these mental health problems.

Many Iraqis living in Jordan have a precarious legal situation. Only 30% have a government-issued residence permit, making it difficult to obtain work legally. The high cost of living means that financial assistance, earnings from informal work, remittances, and savings are often insufficient to sustain their livelihoods.

Prior to reform, the mental health system was highly centralized and mainly based on psychiatric hospitals. Some outpatient services were available, but predominantly restricted to large cities and overall insufficient. Jordan's primary health care (PHC) system covered all parts of the country, including peripheral areas; however, mental health care was not integrated into PHC services.

Turning the emergency into an opportunity to build back better

The flow of displaced Iraqis into Jordan drew the attention of international agencies. Many initiated programmes that offered free assistance to displaced Iraqis and vulnerable Jordanians. Basic health care, psychosocial support, education, and recreational activities were among the services provided.

Although well intentioned, several problems emerged with this rapid influx of services. Many programmes were not based on appropriate needs assessments; as a result, duplication of services occurred in some areas, while unfilled gaps remained in others. The long-term sustainability of the programmes was another concern, as they created a system that was parallel to – but not integrated within – the Jordanian public health system.

WHO arranged for a comprehensive mental health and psychosocial assessment of the situation in 2008. The findings identified challenges in coordination and highlighted the lack of services for those with complex needs and severe mental health disor-

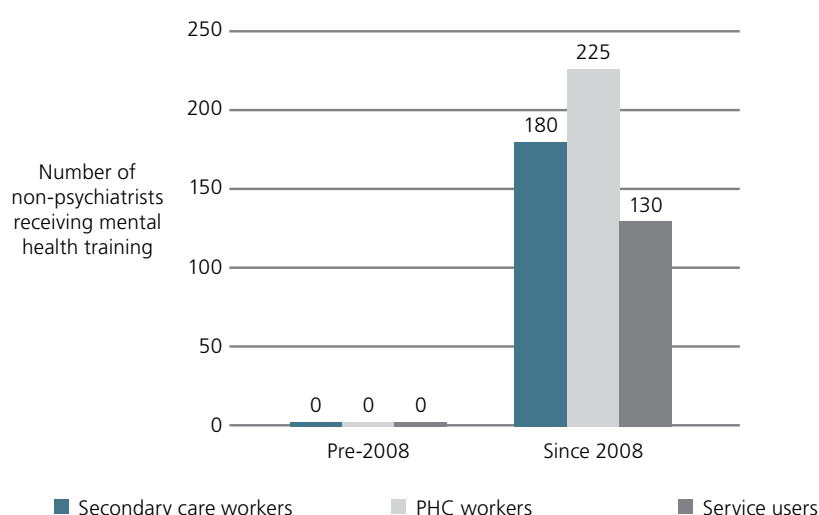
ders. Among the scarcest services were those related to mental health of children and adolescents. WHO recommended shifting focus from a humanitarian to a development agenda and establishing community mental health services. It raised resources to technically and financially support the government in developing such services. Meanwhile, a nascent co-ordination group of diverse mental health and psychosocial support activities was strengthened; WHO and International Medical Corps became co-chairs of the group, which strengthened the links between the government and international and national NGOs.

Progress to date

New community mental health centres

The first action phase of the reform focused on developing community mental health centres in existing Ministry of Health (MOH) facilities. From 2008 to 2009, the MOH and WHO developed three pilot centres, each located in a geographical area with a high concentration of displaced Iraqis: two in Amman and one in Irbid, Jordan's second largest city.

Figure 1. Number of non-psychiatrists receiving mental health training since 2008, Jordan



The community mental health centres (CMHCs) were designed to provide comprehensive bio-psychosocial services in an environment that respects people's dignity and protects their human rights. A multidisciplinary team (see Photo 1) was assigned to each of the three clinics. Members included a senior psychiatrist, a resident psychiatrist, a psychologist, a nurse, a social worker, and an occupational therapist. The psychiatrists were MOH employees, while other team members were initially employed by WHO. Multidisciplinary team members received intensive training inside and outside the country, including specialized training on incorporating human rights into treatment (see Figure 1). The CMHCs provide a wide range of services, including medical treatment, psychological interventions, social assistance, rehabilitation services, psycho-education for people with mental disorders and their families, home visits, and awareness-raising activities in the community.

Child and adolescent mental health care is provided at the main CMHC, through an agreement between the University of Jordan and the MOH. A senior child and adolescent psychiatrist from the university attends to child and adolescent cases at the centre on a bimonthly basis. In addition, the psychiatrist provides supervision and training to the multidisciplinary team and completes specialist assessments and treatment planning for the most complex cases.

The CMHCs have achieved success on several fronts. From 2009 to 2011, 3550 service users received bio-psychosocial treatment with an individualized treatment plan. As a result, the centres started receiving referrals from NGOs, PHC centres, and the community. This attracted the attention of the media and international donors alike, and strengthened the support of the Minister of Health and the Royal Family, especially HRH Princess Muna Al Hussein, the mother of HM King Abdullah II. Furthermore,



Photo 1. Jordan's first multidisciplinary mental health team, established in 2009.
Photo: Anita Marini. Reprinted with permission.

the positive experience of the CMHCs attracted the interest of the Iraqi MOH. As a result, six multidisciplinary teams from Iraq were identified and sent to receive a one-month training in the Jordanian CMHCs.

National policy and plan development

As a result of the effective CMHC field project, a National Steering Committee for Mental Health was formed by the MOH. The Committee's 36 members represented the main mental health stakeholders in Jordan, including service users and community representatives. The Committee was tasked with developing a national mental health policy and plan for Jordan.

The policy and plan were launched in 2011, highlighting 12 areas of action including governance, service organization, human resource development, financial mobilization, human rights and legislation, and prevention and promotion. According to the policy, services should be bio-psychosocial in nature and should feature multidisciplinary interventions, with an emphasis on human rights, user participation, and cultural relevance.

The newly launched policy led to the formation of a new Mental Health Unit within the PHC Department in the MOH. The unit functions as a national mental health authority and coordinates the multiple entities within and outside the MOH that are involved in mental health. It provides overall direction for mental health in Jordan in terms of policies, legislation, service planning, and management.

Service reforms

Historically, mental health services in the country have been inversely distributed compared with the optimal mix of mental health services, as identified by WHO in 2003. Instead of focusing on primary and community-based care, mental health services and resources were devoted mainly to long-term inpatient care in hospitals.

Various recent efforts, including the establishment of the CMHCs described above, have helped correct this inversion of services. A key achievement was the establishment of a new short-stay inpatient unit in the psychiatric hospital. The unit is designed to manage acute exacerbations of symptoms using a bio-psychosocial model and a human rights approach, and to stop further admissions to the psychiatric hospital as a step towards downsizing it. The unit also served to demonstrate a model of care that is suitable for integration within general hospitals.

Subsequent dialogue centred on opening three new inpatient units within general and teaching hospitals. The University for Science and Technology in Irbid opened the first inpatient unit within a general and teaching hospital; plans are under way for Jordan University in Amman to establish a mental health inpatient unit in its teaching hospital. These inpatient units will be alternative training sites to the current psychiatric hospital, and are expected to attract additional students to psychiatry, mental health nursing, and other mental health professions. The establishment of a third inpatient unit is being planned at the MOH general hospital located in Ma'an.

Progress has been made to integrate mental health services within PHC. Jordan is seeking to implement the WHO Mental Health Gap Action Programme (mhGAP), which has produced intervention guide-

lines for PHC-based diagnosis and treatment. Initially, five PHC centres were identified and trained on providing direct care and referring complex cases.

Efforts were made to empower service users as key stakeholders in decisions related to their care, as well as in the community and in policy-making in general. A total of 120 service users were trained on human rights. In 2009, more than 2000 Jordanians celebrated World Mental Health Day (see Photo 2). The first national users' association, Our Step, was established and launched on World Mental Health Day in 2010, while its building was inaugurated in 2011.

Witnessing these mental health reforms, Jordanian Royal Medical Services (the country's second largest health provider) has recently decided to join the efforts in implementing the national mental health policy and plan.

Overcoming ongoing challenges

A challenge to mental health reform in Jordan – as in other countries – was initial reluctance among a number of mental health specialists. Historically, psychiatrists were the sole professionals treating people with mental disorders, and their main approach was biological. The reform has posed a challenge to this approach, as it promoted comprehensive, bio-psychosocial treatment and introduced and emphasized the role of multidisciplinary teams. This challenge was addressed to a large extent through several means: involving all psychiatrists in the reform process; relying on supportive “champions” to serve as change agents within their fields; harnessing the motivation and determination of other mental health professionals to support reform; and benefiting from strong support at the highest political level (different Ministers of Health as well as the Royal Family).



Photo 2. More than 2000 Jordanians gathered to celebrate World Mental Health Day 2009.
Photo: Anita Marini. Reprinted with permission.

Lessons learnt

- Countries can capitalize on international attention and interest in displaced people as a springboard to improve mental health services, as well as other services, for the entire population.
- Mental health reform need not begin with a national policy or plan. In Jordan, a small-scale pilot project was an important first step. The success of the pilot project helped build momentum for larger-scale policy reform.
- A few strong, genuinely passionate and dedicated local champions are essential for reform, even in the face of significant challenges.
- Investing in young, local mental health professionals (in terms of training, mentoring, and study visits) proved to be very helpful. They felt empowered as reformers, and often prioritized the on-going mental health reform over potential personal benefits (such as better salaries or working conditions).
- The involvement of service users is an extremely powerful component of reform.
- Donors can play a pivotal role in mental health reform. In Jordan, they were invited to participate in reform-related activities (workshops, events, ceremonies) and to visit the newly established services. In the process, they became advocates for continuing and sustaining the reform.
- A strong participatory approach for national stakeholders throughout the process is essential for ownership of the reform.
- The non-traditional dual role of WHO as both technical advisor and co-implementing agency was a success.
- Sustained advocacy through the media and other forums was important.
- The support and active participation of national authorities in the reform process are necessary for the successful scaling-up of mental health services.

Another challenge was the turnover of staff at the CMHCs. When CMHC workers were transitioned from employment with the WHO to the MOH, they lost part of their salary and other favourable contract conditions. As a result, around half of them left the CMHCs for other international agencies. Fortunately, the MOH made efforts to replace the psychosocial staff who left the project.

Moreover, significant time and energy were dedicated to gain the support of the six Ministers of Health who served during the project's implementation. Overall, all the ministers were closely involved and very supportive of the mental health reform.

Contributors

Anita Marini, previously Emergency Public Health Officer for Mental Health, WHO Jordan

Hashim Elzein Elmousaad, Epidemiologist and Public Health Specialist, former WHO Representative and Head of Mission in Jordan

Nada Al Ward, Subregional Coordinator, Displaced Iraqis Programme, WHO Jordan

Zein Ayoub, National Mental Health Officer, WHO Jordan

Bassam Hijiawi, Director of Primary Health Care, Ministry of Health, Jordan

Hania Dawani, Mental Health Consultant, Jordanian Nursing Council

Mohammad Assfour, Director, National Mental Health Centre, Jordan

Zuhair Zakaria, President, Jordanian Psychological Association

Tewfik Daradke, Dean of the Medical School and Professor of Psychiatry, Jordanian University of Science and Technology

Abdel Majeed, Professor of Child and Adolescent Psychiatry, Jordan University

Mary Jo Baca, Mental Health Psychosocial and Protection Advisor, International Medical Corps, Jordan

Father Fadi Diab, Episcopal Church, Jordan

Hamdi Murad, Islamic Scholar, Jordan

Our Step (Jordanian National Users Association)

Acknowledgement

The contributors would like to acknowledge technical support and guidance from WHO colleagues in Cairo (WHO Regional Office for the Eastern Mediterranean) and Geneva (Department of Mental Health and Substance Abuse). A special thanks to the Government of the United States of America for financial support of the WHO displaced Iraqi health assistance programme. We are grateful for the support of the Royal Family and the Jordanian Ministry of Health, as well as national and international colleagues in Jordan.

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Kosovo

Summary

Kosovo has endured violence and conflict, which culminated in international intervention and transition of governance to the United Nations (UN) in 1999. This rapid change and interest in mental health created an opportunity to reform Kosovo's mental health system, which until that time had been hospital-focused and biologically oriented. A Mental Health Task Force (MHTF) was formed; it quickly developed a mental health strategic plan to guide further efforts. The strategic plan emphasized the strengthening of community-based mental health services at the same time as closing Kosovo's notorious asylum. Numerous mental health and psychosocial organizations and government donors were present in Kosovo and a number of them contributed to the reform. The strategic plan served as the roadmap, through which all actions could be coordinated. Today, each of Kosovo's seven regions offers a range of community-based mental health services and, despite ongoing challenges, reform is progressing.

Background and context

Kosovo⁵ has suffered from substantial violence and upheaval. Conflict ensued and came to a head in 1998 and 1999. Hundreds of thousands fled their homeland for refugee camps. In June 1999, the government of the Federal Republic of Yugoslavia agreed to withdraw its forces from Kosovo. The United Nations Security Council adopted Resolution 1244 shortly thereafter.

During the 1990s, the overall health system in Kosovo suffered from neglect and lack of funding. The situation worsened further with the 1999 war. Immediately after peace was re-established, facilities struggled to provide even basic health services.

Meanwhile, mental health services in Kosovo were hospital-focused and biologically oriented. Mental

and neurological disorders were managed jointly under the umbrella of a neuropsychiatric system. Primary health care (PHC) services for mental disorders were virtually non-existent; neuropsychiatric wards provided inpatient care that consisted mainly of pharmacological treatment. In addition, an infamous asylum called the Shtime Special Institution housed people with mental and developmental disorders in very poor conditions.

Turning the emergency into an opportunity to build back better

The crisis of 1999 created an opening for mental health reform. Administrative and political changes occurred rapidly. In the midst of this upheaval, mental health stakeholders became receptive to considering new approaches and, at the same time,

⁵ Throughout this document the name Kosovo is used in accordance with United Nations Security Council Resolution 1244 (1999).

external human and financial resources were made available; these needed to be used quickly.

As part of the United Nations Kosovo team, in late 1999 the World Health Organization (WHO) established a mental health unit and conducted a rapid assessment as part of its initial activities. Around the same time, the neuropsychiatric section of the Kosovo Medical Association gathered to discuss reform. WHO met this group and advocated for a new way of managing mental disorders, chiefly through separating the discipline of psychiatry from neurology, developing community-based mental health services, and closing institutions that housed people with long-term mental disorders.

While WHO clarified the kind of approach it advocated and the support it was ready to provide, Kosovar neuropsychiatrists took the situation in hand. As a first step, they created a Mental Health Task Force (MHTF), which consisted of psychiatrists from different regions and representatives of WHO's mental health unit.

This task force was charged with developing a mental health reform strategy. It held regular meetings to discuss new approaches in the field, local problems, hidden resources, and various options for reorganizing services. International experts advised the team, and site visits outside the country were organized.

The Mental Health Strategic Plan was drafted by late 1999 and covered both the mental health policy and the implementation plan. Following extensive consultations and a total of four drafts, the strategic plan was finalized in 2000 and officially approved in 2001. Mental health became one of five priority health areas within the health policy of the relevant authority (the United Nations Interim Administration

Mission in Kosovo (UNMIK)-Health Department), and a specific budget was allocated for the reform. The MHTF became the main consultative body to the UNMIK-Health Department.

Numerous organizations and government donors contributed to the reform in different ways. The Mental Health Strategic Plan was the roadmap through which all actions could be coordinated. To highlight a few examples, WHO – with support from several of its Collaborating Centres – supported community-based reform efforts in three pilot regions. Meanwhile, the Norwegian Red Cross supported reform of Kosovo's asylum, the Shtime Special Institution. Child Advocacy International spearheaded efforts to provide mental health services for children and adolescents. Innumerable other organizations contributed to the reform; many used the Mental Health Strategic Plan as their overall guide.

Progress to date

Mental health services are organized into seven regions within Kosovo. Overall coordination is provided by the mental health unit at the Ministry of Health (MOH). The mental health unit's key func-



Photo 1. M., an inpatient at Shtime Special Institution, Kosovo, 2000. Photo: © Mental Disability Rights International.

tions include administration, supervision, monitoring, and policy development.

A range of mental health services was developed to provide a continuum of care for people with mental health needs (see Table 1). Facilities in each region consist of:

- One community-based mental health centre. The centre is staffed by a multidisciplinary team, and offers a range of outpatient services, as well as support to PHC centres;
- One inpatient ward in a general hospital. The ward provides acute care for those in need of inpatient services;
- One residential facility. This facility offers a limited number of beds to those with severe mental disorders. Residents are usually former patients of Kosovo's asylum (see Photos 1 and 2).

Kosovo's asylum, the Shtime Special Institution, was transformed into the Centre for Integration and Rehabilitation for long-term patients. It is now part of the community-based mental health service

and is managed by the mental health unit of the MOH. The centre has 50 inpatient beds and offers secondary-level services to all seven regions.

Children and adolescents were given special consideration as part of the reform. Regional child and adolescent community-based mental health units were planned to be located physically within the main PHC centres in each region, and under the administration of regional mental health directors. Currently, two units are operational. In addition, a child and adolescent mental health centre is located in Pristina, and is under the responsibility of the University's Department of Psychiatry. A residential facility for 26 young people formerly housed at the Shtime Special Institution was opened by Médecins du Monde and UNICEF; this facility is under the Social Welfare administration.

Some progress has been made to link primary health care to mental health services. Updated training has been provided to all PHC teams. Training covers the new vision of mental health, the need for community-based services, the existence and contents of the Mental Health Strategic Plan, how to work effectively with mental health teams, and basic psychopathology and treatment. At a broader operational level, however, PHC services remain largely separated from community-based mental health services.

In addition to the public services described in this case, the private sector for mental health services is constantly growing. Most psychiatrists work in both the private and public sectors.



Photo 2. M., now living at a residential facility, Kosovo, 2002.
Photo: © Aliriza Arenliu.

Table 1. Summary of changes in facilities in the public mental health sector, 2000–2010

	2000	2005	2010
Community-based mental health centres for adults	0	7	9
Inpatient wards in general hospitals for adults	6	6	6
Residential facilities for adults	0	4	8
Community-based mental health centres for children and adolescents	0	1	1
Primary health care units for children and adolescents	0	2	2
Residential facilities for children and adolescents	0	2	2
Asylums	1	0	0

Overcoming ongoing challenges

Following the 1999 crisis, more than 400 international organizations poured into Kosovo. Many of these organizations wanted to provide mental health and psychosocial services to Kosovars, and were focused mainly on war-related post-traumatic stress. Although well intentioned, many had plans that proved to be unnecessary or unrealistic. Moreover, many assumed that mental health interventions must be short-term. Fuelling this situation, some donors pressed to spend funds rapidly and visibly. As a result, mental health resources were generous but often wasted in the early days.

The Mental Health Task Force and WHO engaged in education and advocacy to counter these approaches. They advocated for a comprehensive, community-based approach to providing mental health services to those in need – as articulated by the Mental Health Strategic Plan.

Resistance had to be overcome on many fronts. For example, there were those who thought asylums were necessary; those interested only in post-traumatic stress disorders; those interested only in the protection and promotion of psychosocial well-

being; those interested mainly in establishing a market for psychoactive pharmaceuticals; those interested in importing new, unproven psychotherapies; those interested in creating visibility for their organizations without considering impact; and those who thought that the Kosovar community was not prepared to sustain a community-based mental health system. Despite these challenges, the process moved forward and ten years later it is still vibrant, due largely to the focus on sustainability and the commitment of local professionals.

Fragmented budgeting for mental health services is an ongoing and major challenge. The MOH's mental health unit still functions in its overall coordination and monitoring roles, but has limited financial resources. Funds for community-based mental health services are allocated directly to the regions, while inpatient wards depend financially and administratively on the Hospital Direction. The mental health unit has little power to influence the regions or the inpatient wards in terms of the services they deliver. The result is fragmentation, duplication, and inadequate coordination of care between outpatient and inpatient settings. Without the establishment of a single administrative organization and budget for

Lessons learnt

- To ensure local ownership of mental health reform, it is crucial to establish a common understanding with local stakeholders on the type of reform to be undertaken.
- A detailed plan should be developed that includes the vision of the future, medium- and long-term goals, strategies and actions, and associated costs.
- Trauma-induced mental disorders are only part of the problem. Local services must be prepared to manage both trauma-related problems and the normally expected range of mental disorders.
- In Kosovo, mental health services at all levels should remain under a single administrative organization that has its own budget line, reporting system, and monitoring mechanisms.
- Changes at both the macro level (policy development, legislation) and the micro level (demonstration experiences in selected geographic areas) are important aspects of reform.
- Training and capacity building for a core group of local professionals contributes to sustainability. This can be facilitated through formal training, day-to-day interactions with international experts, and collaboration with centres of excellence.

mental health services, this situation is unlikely to change.

Besnik Stuja, Mental Health Programme Assistant, WHO Pristina

It is encouraging that most of these concerns – among others – are being addressed through the revised Mental Health Strategic Plan (covering 2008–2013). Reforms are progressing despite the ongoing challenges.

Skender Sylja, Head of Office, WHO Pristina

Liliana Urbina, previously Mental Health Officer, WHO Pristina

Contributors (alphabetical)

Ferid Agani, Minister of Health, Kosovo

Dévora Kestel, previously Mental Health Officer, WHO Pristina; currently Regional Mental Health Advisor, Pan American Health Organization (PAHO/WHO), Washington, DC

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Somalia

Summary

Somalia's governance structure has been in turmoil for more than 20 years, and during most of that time the country has been riddled with humanitarian emergencies caused by conflict. The Somali people have suffered greatly as a result. The country's mental health services are poorly resourced, and misunderstandings about the nature of mental disorders are common within the general population. As a result, people with mental disorders frequently experience stigma and inhumane treatment. Despite severe challenges, progress has been made. This case demonstrates that important improvements in mental health services can be achieved in contexts where national capacity for instituting and overseeing reform is lacking.

Background and context

Somalia is an East African country that has been in a state of internal discord since 1991. Following the civil war of that year, the country was split into three zones: northwest Somalia, known as Somaliland; northeast Somalia, known as Puntland; and south/central Somalia. Each zone has its own quasi-administration. The authorities in northwest Somalia have judiciary, legislative, and executive systems. Similar ministries exist in northeast Somalia. The south/central zone of Somalia remains locked in conflict and violence between opposing factions; the security situation has severely hindered and restricted international humanitarian assistance. A Transitional Federal Government (TFG) has been in place since 2009 and has negotiated a roadmap for forming a new central government.

The situation has resulted in a generation of Somalis being without adequate access to basic services and the collapse of public institutions for health and welfare. Somalia's current population is roughly 8 million people, although estimates range from 6 to 11 million. At the time of writing, around 1.5 million people

are internally displaced across the country, while some 2.4 million Somalis are experiencing food crises, representing 32% of the entire population. More than 80% of the population are estimated to be illiterate.

Even before the outbreak of the conflict, the health system in Somalia was weak and underfunded. In 1989, the Ministry of Health was allocated 2.9% of the government's regular budget. In 1984, external aid constituted 67% of the total health budget, and this proportion increased to 95% in 1990. Mental health services consisted mainly of institutional care in three psychiatric facilities. In these facilities, living conditions were dismal, basic hygiene poor, and psychotropic drugs almost non-existent. Many people with mental disorders were routinely chained. More generally, the country suffered from a severe shortage of mental health workers: only five trained psychiatrists, insufficient and poorly trained nursing staff, and no clinical psychologists or psychiatrist social workers. Mental health services were not available through primary health care (PHC) or otherwise available in the community. Many Somalis held the belief that mental disorders were due to demons and

spirits and sought help only from traditional healers. As a result, most people with mental disorders did not receive any sort of modern mental health care.

Turning the emergency into an opportunity to build back better

Due to the ongoing crisis and weak governance structures, full reform of the mental health system has not been possible. Nonetheless, significant progress has been made.

Most of the work has been financed by emergency funds directed towards alleviating the suffering in the Somali population. The media have extensively reported the plight of Somalis, and numerous studies have documented a high rate of traumatic events, substance abuse, and mental disorders. This attention likely fuelled the interest of donors in addressing the mental health of Somalis, which in turn has created opportunities for improvement of the mental health system.

Chain-Free Initiative

The Chain-Free Initiative – developed by the World Health Organization (WHO) – was launched in Mogadishu in 2006, and later expanded to Somaliland and Puntland. The initiative has focused on improving the quality of life of people with mental disorders through combating stigma and facilitating humane treatment in hospitals, at home, and in their communities. The first phase of the initiative has involved creating chain-free hospitals by removing chains and, more generally, through the aim of reforming hospitals into humane facilities with minimum restraints. The second phase has focused on private residences by providing education and training to families of people with mental disorders. The

final phase involves removing the “invisible chains” of societal stigma and human rights restrictions on people with mental disorders.

Health worker training

Several international organizations have been active in training health workers to deliver mental health services.

In 2005 and 2009, WHO conducted 3-month training courses for health workers from all zones of Somalia. The aim of these courses was to equip PHC workers with a good understanding of priority mental disorders and their management. Participants gained knowledge and skills for providing and organizing mental health care in the community, while taking into account the resource constraints in the country.

Parallel to these efforts, work has been under way specifically in Somaliland. The King's THET Somaliland Partnership (KTSP) – a mental health group established by King's College Hospital, London, the Tropical Health and Education Trust, and numerous other partners – has supported the development of the health workforce through training, as well as via salary support, mentoring, and support of leadership and governance in training institutions and professional organizations. As part of overall health workforce development, mental health issues have been incorporated into the training of a wide variety of health workers. The Mental Health Gap Action Programme Intervention Guide is now part of the curriculum of two medical schools, Amoud University and Hargeisa University. In addition, two selected junior doctors (interns) have received training to be mental health representatives in order to actively integrate mental health care into existing health systems.

Moreover, the international nongovernmental organization (NGO) vivo and the University of Konstanz in Germany have trained social workers in Somaliland.

Since 2003, the Italian NGO Grupo per le Relazioni Transculturali (GRT) has focused on building the capacity of health workers in Puntland, and later also in Somaliland. Training has emphasized diagnosing and treating common mental disorders, prescribing psychotropic medications, establishing rehabilitation plans for people with mental disorders and their families, and engaging communities through awareness raising and advocacy.

Mental health situation analysis

Assessments of the mental health system in Somalia, one concerning Mogadishu and the south/central zone, and the other covering the Somaliland region, were published in 2006 and 2009, respectively. Both used WHO's Assessment Instrument for Mental Health Systems (WHO-AIMS) as their basis. The analyses confirmed that mental health systems in Somalia were notably weak, due mainly to the ongoing conflict and instability. In Somaliland, some progress had been made recently, including the creation of a mental health division within the Ministry of Health (MOH), the development of a mental health budget within the overall health budget, and refresher training for health workers.

The WHO country office undertook an additional situation analysis in 2010, to better understand the mental health situation as a whole, and to raise the profile of mental health within the health agenda. The analysis found that mental disorders were highly prevalent throughout the country, presumably due to ongoing insecurity, war-related traumatic events, poverty, unemployment, and khat use. Despite this significant burden, it was also observed that mental health was one of the most poorly funded public health areas. According to the report, legislation, policies, and governance mechanisms were not in place, and mental health services and facilities were insufficient in number, lacked proper equipment and supplies, and suffered shortages of health workers. People with mental disorders were stigmatized and socially isolated. Degrading and unsafe cultural practices, such as being restrained with chains, were not only widespread, but also accepted within society and the medical community.

Progress to date

Habeb Mental Hospital in Mogadishu has implemented all three phases of the chain-free initiative. Chains were removed from more than 1700 people between 2007 and 2010 (see Table 1). Currently, no one is chained in this facility. Meanwhile, the number of people accessing services at the hospital has increased significantly, as community members

Table 1. Number of people whose chains were removed, 2007–2010

Within Habeb Hospital	1355
Within private residences in the surrounding community	417

started to realize the importance of seeking treatment for their relatives with mental disorders. Strong political commitment by the TFG Minister of Health has drawn attention to the issue (see Photo 1); public awareness has been strengthened through media coverage of the topic. The chain-free initiative has now expanded to all regions of the country.

WHO's training courses built the capacity of 55 health workers from the three zones of Somalia. In addition, the training identified people who have the ability to take this work forward: two participants are now mental health coordinators/focal points in Puntland and Somaliland. Three newly established mental health facilities are managed by participants.

The mental health situation analyses raised awareness among national and local partners and helped attract the attention of donors. The European Union recently provided funding for a mental health project in Puntland and Somaliland, and emergency funding mechanisms have been used by WHO to acquire additional resources. Mental health is now discussed regularly in health sector coordination meetings. A national mental health policy working group is in place, a strategy has been developed, and integrating mental health into primary health care is a priority of health authorities.



Photo 1. “When the doctor requested me to remove the chains, and the wife started to object, I did not know what to do ... [however,] as the doctor was insisting to remove [the chains], I had to decide, and I started to remove [them] ... to my surprise and the bewilderment of everybody present, the patient stood up and kissed my face,” said Dr Aden Haji Ibrahim, TFG Minister of Health and Human Services. Photo: © Habeb Hospital, Mogadishu. Reprinted with permission.

Lessons learnt

- Important improvements in mental health services can also happen in contexts where full-scale national mental health reform is not possible.
- A situation analysis of the mental health system can focus the attention of health actors and donors on population needs and areas for action.
- Capacity building of health workers is often an essential step to improving the quality of mental health services and spreading change.
- Inhumane behaviour such as routine chaining of people with mental disorders can be changed, but this requires coordinated advocacy and communication involving the mass media, community elders, and one-on-one discussions.
- Overt commitment from political leaders can accelerate change.

Overcoming ongoing challenges

Despite important steps towards improving the mental health situation in Somalia, full reform has not been possible. The lack of an effective central governance structure is among the greatest challenges; more specifically, lack of funds and infrastructure directed to mental health has inhibited larger-scale improvement. Dedicated mental health budgets, continuous drug supplies, training of additional health workers, integration of mental health care into a range of health services, and a coherent policy framework are just a few of the steps required to ensure a properly functioning and sustainable mental health programme in Somalia.

Contributors

Humayun Rizwan, Medical Officer, WHO Somalia

Mohammad Fuje, National Programme Officer, WHO Somalia

Martha Everard, WHO Representative for Somalia

Khalid Saeed, Regional Adviser for Mental Health, WHO Regional Office for the Eastern Mediterranean

Abdur Rehman Ali Awale, Habeb Hospital, Mogadishu, Somalia

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Sri Lanka

Summary

In the aftermath of the 2004 tsunami, Sri Lanka made significant strides towards the development of efficient, comprehensive, and integrated community-based mental health services. Previously, most mental health services were provided through tertiary-level hospitals in major cities, mainly near Colombo; trained mental health workers were scarce in other parts of the country. Sri Lanka was able to coordinate and thus capitalize on the resources flowing into the country following the tsunami to make a leap forward in the development of mental health services. Improvements were achieved by working with a broad range of stakeholders and by creating networks of support and technical assistance.

Background and context

Sri Lanka is an island country in the Indian Ocean, located south of India, with a multi-ethnic population of approximately 21 million. It is a lower middle-income country. Its distribution of wealth is uneven: poverty in rural areas is three times that in urban areas. Three decades of civil war have impeded socioeconomic development.

The tsunami of 26 December 2004 was the worst natural disaster in Sri Lanka's recorded history. This disaster occurred in the midst of an already complex political and social environment: some of the devastated areas had been affected by protracted civil conflict. In addition to the immediate loss of more than 35 000 lives, the tsunami caused extensive damage to schools, hospitals, businesses, and other infrastructure. Around one million people were displaced across the tsunami-affected districts (see Photo 1).

Prior to the tsunami, and despite many efforts and important initiatives, most mental health services were provided through tertiary-level hospitals in major cities, mainly near the capital, Colombo. Trained mental health workers were scarce in other parts of

the country. This meant that most people with mental health needs failed to receive any sort of treatment.

Turning the emergency into an opportunity to build back better

Following the tsunami, Sri Lanka's head of state recognized the need to address the acute psychological distress of survivors. Fuelled by international media interest and rapid resolution of other health issues, mental health became a prominent part of the po-



Photo 1. A woman and her child rest in the remains of their home, which was devastated by the tsunami of 2004.
Photo: © WHO. Reprinted with permission.

litical agenda. A presidential taskforce was established to provide support for mental health relief. Initially, a social needs approach was recommended, focusing on immediate needs such as provision of information, keeping family members together, early reopening of schools, resumption of essential services, and responding to basic needs of survivors. At the same time, Sri Lanka's Ministry of Health (MOH) promoted broader, national mental health reform. After intense negotiations with technical support from the World Health Organization (WHO), mental health professionals – who had been at odds with one other – agreed eventually on a new national mental health policy, which the Sri Lankan government approved only ten months after the disaster.

The new policy, effective from 2005 to 2015, emphasizes comprehensive, decentralized, and community-based care. It calls for the reconfiguration of mental health services so that care can be locally accessible. Every district is required to establish acute inpatient wards, as well as a broad range of community-based services, including fixed and mobile outpatient care and community support centres, with referral up and down the different levels of care. A multidisciplinary mental health team provides services within each district. To support implementation, the national policy also calls for the creation of new mental health governance structures and a renewed focus on human resource development. In addition, it establishes a National Institute for Mental Health and a national strategy for reducing stigma and discrimination. Finally, it calls for the development of mental health legislation to safeguard the human rights of people with mental disorders.

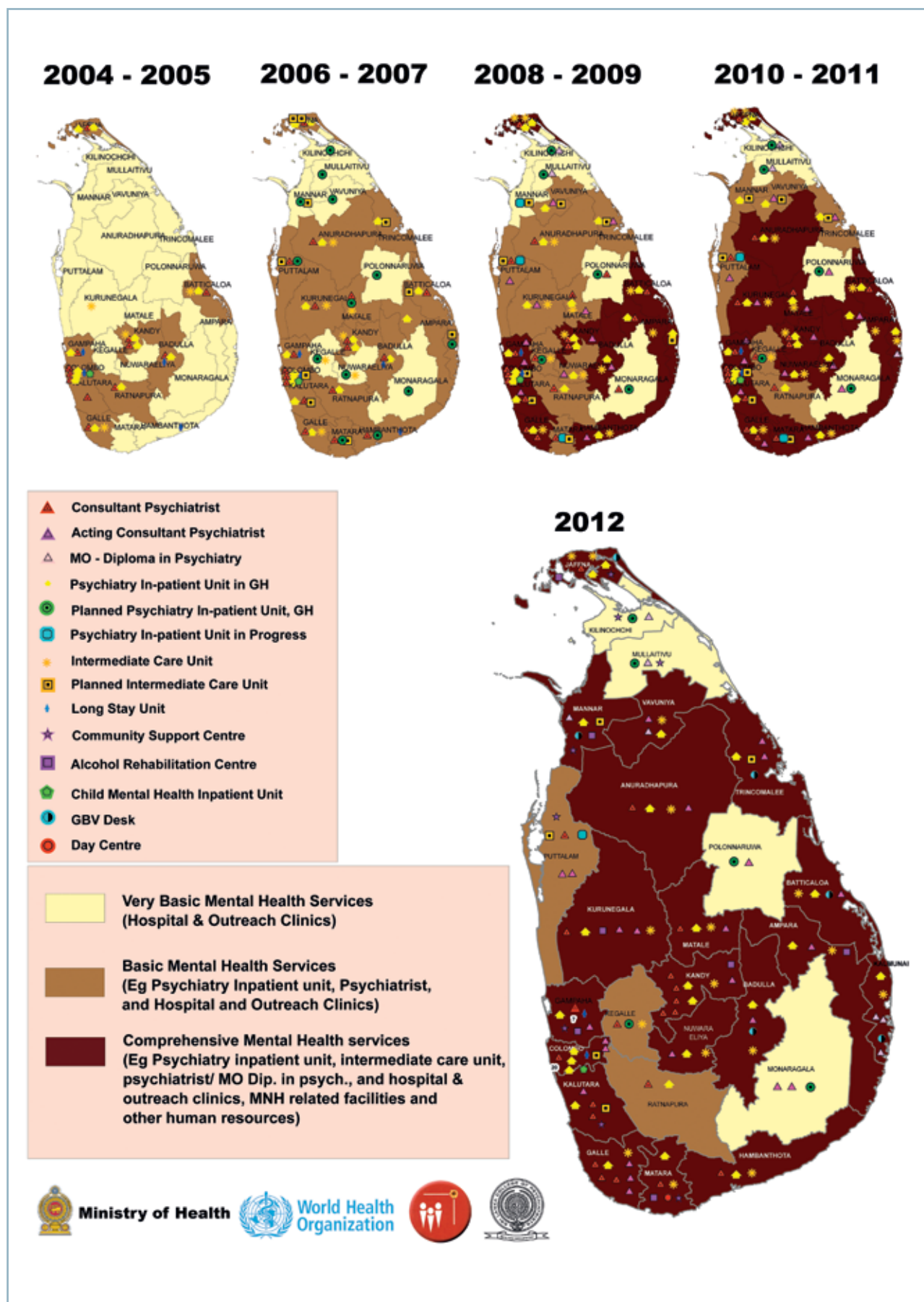
Consistent with the national policy, the National Mental Health Advisory Council (NMHAC) was formed in 2008 to oversee implementation of the

mental health policy in Sri Lanka. The NMHAC is chaired by the Secretary of the MOH and its members are MOH officials and representatives from other relevant ministries, professional bodies, WHO, NGOs, and of service users and carers.

With the national policy as the overall guide, various programmes were undertaken at national and district levels. Although a wide range of agencies and donors supported diverse, inefficient, or potentially harmful practices, a smaller number of donors and implementing agencies contributed to the collective effort of implementing the national policy. WHO – funded by the Government of Finland – contributed to the development of mental health services, particularly in six districts, and played a catalytic role in convening health partners and donor agencies to support mental health reform. On the eastern shore of the country, the Austrian and Swiss Red Cross built a rehabilitation centre in Batticaloa, while Médecins du Monde Greece built an acute psychiatric unit within Valachchenai Hospital in the same district in close collaboration and with technical guidance from WHO. Médicos del Mundo Spain helped develop a mental health inpatient unit in Trincomalee Hospital, and trained and supported a complementary community outreach team.

The International Medical Corps provided mental health training to primary health care (PHC) doctors across the south-eastern districts of Kalmunai and Ampara and the Southern Province district of Hambantota. Canada's Centre for Addiction and Mental Health funded capacity-building programmes and assisted in strengthening coordination across some tsunami-affected districts. The University of Toronto in Canada supported the acute psychiatric unit in Mannar Hospital, located in the north-west of the country. The Irish

Figure 1. Expansion of mental health services in Sri Lanka



Government funded the appointment of community support officers in some districts. The International Medical Health Organization funded capacity-building programmes in the Northern and Eastern Provinces, and built an acute psychiatric unit at Vavuniya Hospital in the north of the country. The United Nations Population Fund provided transport facilities to tsunami-affected districts, thereby facilitating mental health outreach clinics.

World Vision Australia funded a mental health system development project in the Southern Province between 2007 and 2010. The project established a full range of community mental health services in all three districts of the province. To make this possible, large numbers of health workers were trained and deployed to areas of relevant need. World Vision is also active in the Northern Province, where it is supporting the development of community-based services across five districts.

Community empowerment was another area of action. The government mental health unit in Batticaloa, as well as Basic Needs, an NGO, contributed to the establishment of consumer groups in some districts. Later, the MOH established consumer civil society groups across the country, with technical and funding support from WHO. Sensitizing the media on mental health issues and disseminating health education materials aimed to reduce the stigma associated with mental disorders and facilitated community involvement and partnerships.

Progress to date

Sri Lanka has made significant strides towards the development of efficient, comprehensive, and integrated community-based mental health services (see Figure 1). Although mental health has lost promi-

nence within the political agenda compared with the year following the tsunami, national and international investments in mental health have continued. This has enabled Sri Lanka to continue to build on the early momentum.

As of 2011, 20 out of 26 health districts (77%) had functioning acute inpatient units within general hospital settings, compared with 10 out of 26 (38%) before the tsunami. In addition, the country had 16 fully functional intermediate stay rehabilitation units, compared with five units in 2004. The establishment of acute care units and intermediate care facilities has helped to expand basic and specialized mental health services in the country. The staffed acute inpatient units in the districts are especially important because they are the base from which other mental health activities (e.g. outreach clinics, training of PHC workers) are organized locally.

Mental health outreach clinics have been established in divisions (sub-districts) in many districts of the country, enabling people with mental disorders to live and be treated close to their homes (see Photo 2). This is likely to have contributed to the reduction in (re)admissions to acute care units and mental hospitals. Nearly 30 community support centres have been established, promoting community involvement and education.

Progress has been dependent on the training and deployment of a range of mental health workers, as already described. Collectively, these workers are well positioned to provide comprehensive, multidisciplinary care.

The national mental health policy has also improved the quality of services provided in hospitals. The Mental Hospital at Angoda in Colombo district, commis-

sioned in 1927 as a “lunatic asylum”, has evolved rapidly in recent years, and is now the country’s National Institute of Mental Health. The institute plays an integral role in Sri Lanka by providing specialized psychiatric services, as well as serving as the national centre for mental health training and research.

Overcoming ongoing challenges

The lack of trained mental health professionals has been one of the greatest challenges in implementing Sri Lanka’s mental health reform. Innovative approaches have been adopted to address these shortfalls.

At the national level, the MOH and the Sri Lanka College of Psychiatrists (SLCP) have initiated a one-year diploma course in psychiatry. Participants receive specialized training in psychiatry, including theory and field placement under the supervision of a consultant psychiatrist. To complete the diploma, all are required to pass an exam conducted by the Postgraduate Institute of Medicine (PGIM) at the University of Colombo. Because the diploma is not internationally recognized, graduates tend to stay in the country after their training. Since 2010, the MOH and the SLCP have been conducting this diploma course without any external assistance, demonstrating their commitment to its sustainability. Nearly 60 diploma holders are now working in Sri Lanka, and all 25 districts in the country have at least one doctor with the diploma in psychiatry. They are based mainly in secondary-level hospitals, and conduct hospital as well as outreach clinics in the district. They are also involved in community-level mental health activities.

Apart from psychiatry diploma graduates, 131 Medical Officers of Mental Health and 34 Medical Officers of Psychiatry are now serving in different parts

of the country. Medical Officers of Mental Health – an innovative Sri Lankan cadre that existed before the tsunami and which has been expanded since – receive three months of mental health training. Their duty list is similar to that of psychiatry diploma holders, and they work under the supervision of district psychiatrists. Medical Officers of Psychiatry receive basic training as part of their pre-service curriculum, and they work in hospital settings formally under the supervision of a consultant psychiatrist. In many districts they fulfil, de facto, the role of leading the mental health response, and are important resources for the public health administration.

Other mental health professionals have also been developed. Forty-six newly trained community mental health nurses have been appointed to different districts. Each received two months of specialized training prior to deployment. They provide follow-up care in communities and work closely with PHC staff attached to MOH offices. In addition, the University of Colombo has developed a curriculum for psychologists.



Photo 2. A Medical Officer of Mental Health conducts a clinic with the participation of Community Service Officers (CSOs).
Photo: © WHO. Reprinted with permission.

Lessons learnt

- It is possible to use short-term political interest in mental health to initiate the scaling-up of community-based mental health care.
- A coherent mental health policy framework is essential. If a common, formally approved vision does not exist, it must be created in a participatory manner.
- If developed by the government and involving key stakeholders, a policy framework can facilitate strong support from different levels of government and health partners, and serve as an attractive basis for developing funding proposals.
- Proper coordination at all levels is key to ensure that different donor investments can be made without duplication.
- Acute care units in districts help expand delivery of basic and specialized mental health services and reduce the burden on the community. In districts with no mental health services previously, acute care units can be the “base” from which community mental health activities are organized.
- Outreach clinics in divisions (sub-districts) improve accessibility to mental health services and reduce the treatment gap.
- Locally recruited lay mental health workers increase client trust and confidentiality, reduce family and community stigma, and improve acceptance of treatment for mental disorders.

In tsunami-affected areas, new community-level mental health workers, known as Community Support Officers (CSOs), have been trained and deployed to districts struck by the tsunami. More than 500 CSOs were recruited using external funds. Each was a member of the specific community in which he or she was subsequently assigned. This helped ensure that their interventions were culturally appropriate and acceptable. It also helped increase acceptance and trust of CSOs by communities, thereby reducing stigma regarding mental health issues and enhancing acceptance of treatment. Thanks to the country's high level of liter-

acy, identifying suitable people among affected communities for CSO training was not difficult. Medical Officers of Mental Health provide supervision of CSOs.

CSOs identify people in their communities with psychosocial problems and provide them with practical support, such as helping them to access available financial resources. They also help spot those with early signs of mental disorders and facilitate their referral to appropriate health facilities. Importantly, CSOs promote adherence to regimes among people receiving treatment for mental disorders.

Because the CSO programme was administratively and technically embedded within the districts' public health services, it was quickly integrated into the health system. A formal evaluation concluded that CSOs significantly enhance both overall access and coverage of mental health services to communities, especially in areas where there was limited or no access to mental health care previously.

Although the government has not funded the CSO cadre, and although the diploma course in psychiatry has led to some resistance, Sri Lanka has been able to identify and implement innovative solutions to the shortage of mental health workers in tsunami-affected areas, and in the country more broadly.

Contributors

T Suveendran, National Consultant – Mental Health, WHO Sri Lanka

FR Mehta, WHO Representative to Sri Lanka

Jayan Mendis, Director and Consultant Psychiatrist, National Institute of Mental Health, Sri Lanka

M Ganesan, Consultant Psychiatrist, National Institute of Mental Health, Sri Lanka

TRC Ruberu, Secretary, Ministry of Health, Sri Lanka

PG Mahipala, Additional Secretary – Medical Services, Ministry of Health, Sri Lanka

Lakshmi C Somatunga, formerly Director of Mental Health, Ministry of Health, Sri Lanka

Prasantha de Silva, Consultant – Directorate of Mental Health, Ministry of Health, Sri Lanka

Berit Kieselbach, United Nations Volunteer and Programme Officer, WHO Sri Lanka (2006–2008)

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Timor-Leste

Summary

Prior to the humanitarian emergency of 1999, there were no mental health professionals or mental health specialist services in Timor-Leste. Although this meant that Timorese people did not have access to mental health treatment, it also created an opportunity to establish mental health care consistent with best practice guidance. Leaders of the effort focused on training and supporting health workers to provide an effective community-based mental health service, which later became increasingly integrated with primary health care. Today, Timor-Leste's National Mental Health Strategy (2010–2030) is part of the Ministry of Health's overall long-term strategic plan. The country's mental health services are organized across three tiers: under the system, primary care nurses assess and treat most cases; district mental health workers provide specialist consultation as needed; and a psychiatrist is responsible for the most complex clinical situations and overall clinical leadership. This case study focuses on some of the key issues confronted during the past 10 years in the process of service development.

Background and context

Timor-Leste is a half-island country situated between Australia and the eastern islands of Indonesia (see Photos 1 and 2). It was under Indonesian rule for 24 years, prior to achieving independence in 2002. The 1980s and 1990s were marked by extensive human

rights violations, military conflict, and mass displacement of populations, which deteriorated into a humanitarian emergency in 1999 following a vote on independence. The country remains one of the poorest in Asia, with 50% of its one million people living below the national poverty line of US\$ 0.88 per day.



Photo 1. Timor-Leste is one of Asia's poorest countries, with half its population living below the national poverty line.
Photo: Zoe Hawkins. Reprinted with permission.



Photo 2. Before 1999, the Timorese people had no access to mental health services.

Photo: Zoe Hawkins. Reprinted with permission.

Prior to the humanitarian emergency of 1999, there were no mental health professionals or mental health specialist services in the country. On top of this, many primary health care clinics were destroyed during the conflict. Although this meant that the Timorese did not have appropriate access to any form of mental health service, it also created an opportunity to establish a model of mental health care that was consistent with best practice guidance.

Turning the emergency into an opportunity to build back better

In 2000, a consortium of Australian agencies led by the Psychiatry Research and Teaching Unit of the University of New South Wales began developing the first ever mental health services in Timor-Leste. Although the agency that was formed, Psychosocial Recovery and Development in East Timor (PRADET), was independent, it had strong ties with the provisional Health Authority and received support from the Australian Government's overseas development agency, AusAID.

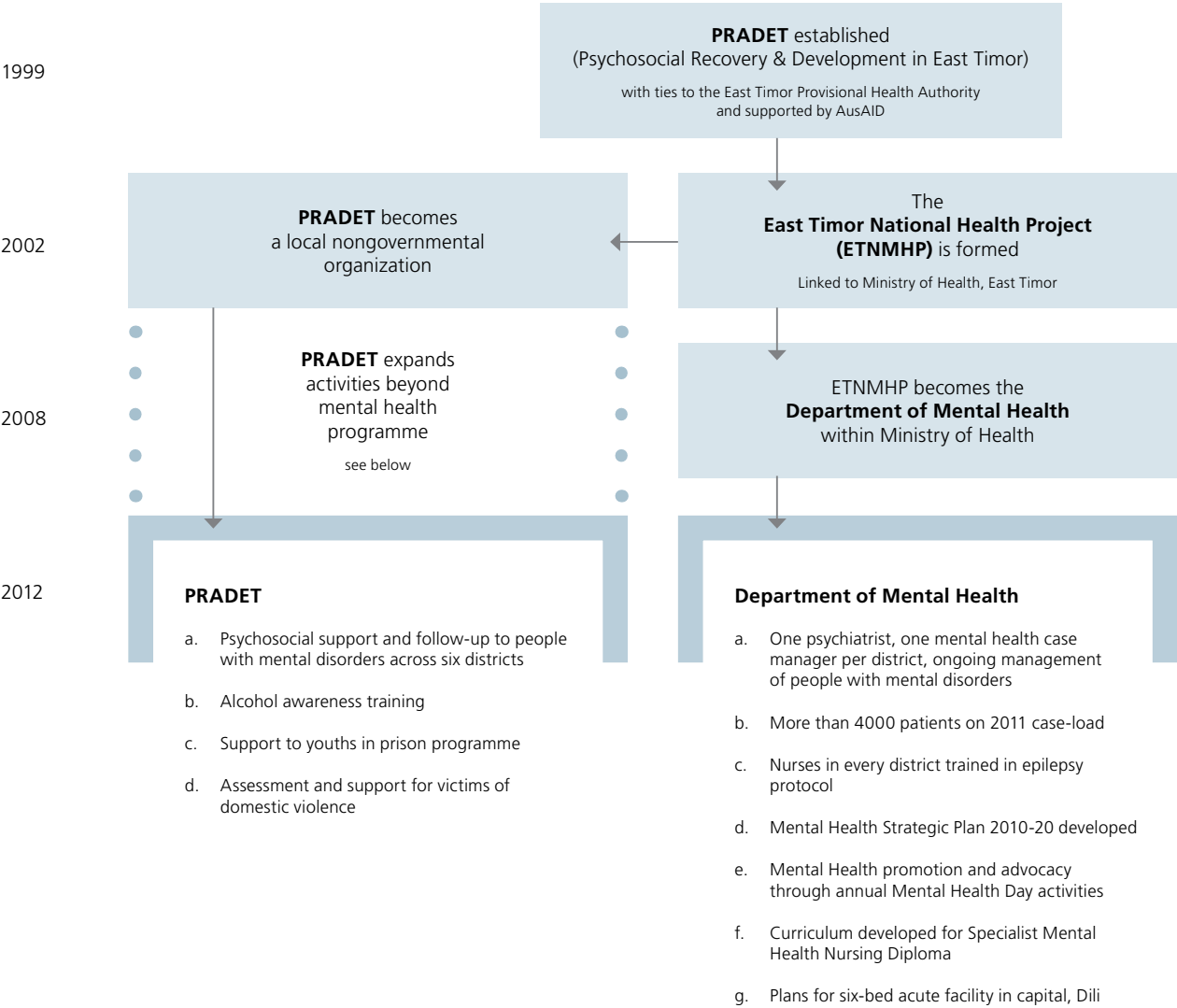
At the outset, the leaders of PRADET were confronted with choices regarding the scope and focus of

the new mental health service. They were mindful of the ongoing controversies in the field in relation to competing models: whether to give primary focus to trauma-related psychological reactions such as post-traumatic stress disorder (PTSD); to broader psychosocial support programmes focusing on vulnerable groups; or to generic clinical services for those with severe mental disorders (mindful of the substantial overlap among these populations). A number of considerations shaped their decision: limitations of the initial funding (approximately US\$ 300 000 over two years); recognition that there were no established mental health services in the country; indications that people with severe mental disorders were at particularly heightened risk; and expectation that the re-establishment of safety and order (achieved rapidly in Timor-Leste by the United Nations' intervention) would allow many common stress reactions to resolve spontaneously.

PRADET therefore adopted the following principles: the service would be community-based, with a strong emphasis on outreach and support for families; the establishment of inpatient facilities would be deferred; and the service would be organizationally independent of primary care facilities, which had been severely damaged and were struggling to provide even the most rudimentary care. Nevertheless, opportunities would be sought to integrate mental health with primary care services over time. People would be treated for a range of mental disorders and manifestations of psychological distress, with priority attention given to those in greatest social need, meaning those with severe mental health problems.

The service rapidly established a large referral base. PRADET formed strong links with the police, general health services, and other nongovernmental orga-

Figure 1. Progress in developing mental health services in Timor-Leste



nizations (NGOs). The agency engaged in broader activities such as awareness raising, advocacy, policy development, and education. In addition, it provided support for other NGOs that were established later to provide specialist counselling for survivors of traumatic events.

At the outset, PRADET’s leaders recognized the risk of attempting to “do too much with too little”. Instead, they focused on the training and support of health workers to provide an effective community-based mental health service. Given that those with severe mental disorders such as psychosis required

most attention, health workers had only limited time to become skilled in the use of specific psychological treatments, such as cognitive-behavioural therapies for PTSD and other traumatic stress reactions.

Progress to date

This case study highlights some of the key progress to date. Issues such as capacity building, research, personnel management, training, and supervision have been discussed in separate publications (see related publications list below). Overall progress is summarized in Figure 1.

Initially, PRADET trained 16 Timorese health workers, first in Australia and then in Timor-Leste itself. Later, PRADET became a local NGO, continuing to play a prominent role in mental health and psychosocial support. In 2002, the East Timor National Mental Health Project (ETNMHP – now the Department of Mental Health) was established under the Ministry of Health (MOH).

A multidisciplinary team of mental health professionals from Australia and other countries provided extensive input into training and supervision of mental health workers from 2000 to 2005. In addition to classroom-based training, psychiatrists and other mental health professionals spent extensive time in the field working side-by-side with Timorese colleagues. International staff provided on-site mentoring and supervision and feedback in relation to interviewing, making diagnoses, and formulating treatment plans, as well as in developing wider-ranging skills.

The shift to a primary care model, a more recent development in Timor-Leste, is consistent with best practice guidelines. In principle, Timor-Leste now has a three-tier system: primary care nurses are tasked with assessing and treating most cases; district mental health workers (positioned in all of the country's 13 districts) provide specialist consultation as needed; and one psychiatrist is responsible for the most complex clinical situations and provides overall clinical leadership. Currently, mental health-trained general nurses are available in around one quarter of the country's 65 community health centres (see Photo 3). Each district has a caseload of approximately 100 to 200 people at any one time.

Timor-Leste's National Mental Health Strategy (2010–2030) is part of the overall long-term strate-

gic plan of the MOH. The strategy describes a series of objectives with indicators, one of which is to improve access to mental health services by increasing the number of community health centres staffed by mental health-trained general nurses. The goal is to achieve 100% coverage by 2030.

Overcoming ongoing challenges

The programme was faced from the outset with the challenges of sustainability and transitioning to a longer-term development phase for mental health services. Several factors made longer-term strategic planning difficult. Short-term humanitarian funding meant that there were no guarantees that the programme would continue beyond the early years following the emergency. In addition, institutions that were essential to strategic planning, particularly the MOH, were still in the process of formation. Changes in personnel, administrative structures, and decision-making processes were inevitable in this period of rapid transition.

With the termination of international donor funding, it was no longer possible to maintain the sys-



Photo 3. A district community health centre in Timor-Leste.
Photo: Zoe Hawkins. Reprinted with permission.

tematic programme of international support for training and supervision. The MOH's Institute of Health Sciences, founded in 2005, assumed these functions. The Institute has developed a new curriculum for mental health nursing, and it initiated this two-year course of study in 2011–2012. In addition, the first Timorese psychiatrist has completed training in Papua New Guinea. Nevertheless, challenges remain in providing regular professional support, peer contact, supervision, and training for mental health-trained workers, especially those in remote settings. The risk is that their motivation and skills may diminish over time as a consequence of professional isolation.

There are no simple solutions to some of the challenges, such as ensuring the sustainability of programmes from the outset, particularly when initiated during humanitarian crises. One strategy is to dedicate more time to educating policy-makers from donor countries and international agencies to better understand that development of the mental health system will benefit from a long-term commitment that extends beyond the provision of emergency services. In addition, it is vital that international leaders in mental health achieve consensus in relation to the priority focus of services in these settings. Finally, whereas there is consensus that mental health should form an integral part of primary care ser-

Lessons learnt

- Community consultations are vital. They give a voice to the community, empower and involve local people, engender trust, and ensure that foreign models are not imposed.
- Mental health policy should be integrated into general health policy as early as possible to develop a culture of mental health being part of, rather than separate from, general health.
- Strong political will can be fostered through developing close partnerships with all levels of government from the outset.
- Policy-makers often need to be educated about the risks and costs of institutional care for people with mental disorders, as well as about the existence of alternative, community-based models of care.
- Health workers are key to service development. They must be trained to provide mental health care, and they must receive ongoing support and supervision to ensure that this training is applied effectively over time. They must also operate within an integrated system of care in which their roles and boundaries are clearly defined in relation to others.
- Close communication with relevant NGOs ensures that there is no duplication of services and therefore no waste of limited resources.

vices, further research on implementation is needed to identify the conditions and systems that ensure that this model is maximally effective and sustainable. This includes giving mental health a high status within the mix of services; ensuring that basic resources are provided, such as essential psychotropic medicines; developing complementary services that many people with mental disorders and their families need (housing, rehabilitation, work, respite); providing nurses with ongoing supervision, mentorship, and opportunities for advanced training; and establishing clear and efficient lines of referral to ensure that complex cases receive expert attention.

Contributors

Derrick Silove, previously Director, PRADET, and Professor of Psychiatry, University of New South Wales

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West Bank and Gaza Strip

Summary

In spite of ongoing occupation and conflict, significant improvements have been made over the past decade in the mental health system in the West Bank and Gaza Strip. The Palestinian Ministry of Health (MOH), with the support of a wide range of stakeholder groups, has developed a new vision for mental health care. The system has started to move towards community-based care, and progress has been made on the integration of mental health into the government's primary health care (PHC) clinics. Ongoing challenges to further reform efforts include the continuing occupation, the fragmentation of the Palestinian territory and its leadership, the lack of appropriate coordination between different service providers, and repeated funding gaps for programme implementation. Despite this, the MOH and its partners are committed to continuing with mental health reform.

Background and context

The occupied Palestinian territory comprises two geographically separate areas, which have experienced numerous decades of occupation and intermittent conflict and unrest. This has caused a great deal of suffering and worsening economic conditions (see Photo 1).

The Palestinian population's mental health needs are considerable and are exacerbated by continued conflict and violence; high population density with a significant proportion of the population living as refugees (see Photo 2); significant unemployment, social deprivation, and poverty; and ongoing experiences of loss, traumatic events, and human rights violations.

The Palestinian MOH is the main health-care provider in the territory and is responsible for the overall supervision, regulation, licensing, and control of the health system. Since 2007, the MOH has been split between the Palestinian Authority in the West Bank and the *de facto* authorities in Gaza. A number of other health-care providers also operate within the territory, in-

cluding the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), a range of national and international nongovernmental organizations (NGOs), and private care providers.

In 2000, the MOH's mental health resources (more than 90% of its staff and budgets, and 100% of its inpatient beds) were concentrated in tertiary psychi-



Photo 1. Farid Batch standing next to the remains of his home in the Gaza Strip. At the time this photo was taken in 2010, his most urgent priority was finding somewhere for his family to live. Photo: © Phoebe Greenwood/IRIN. Reprinted with permission.

atric care at the Bethlehem Psychiatric Hospital and Gaza Nasr Hospital, despite the existence of community mental health clinics in the West Bank and Gaza Strip. Primary health workers had little or no training in diagnosing and treating mental disorder and little investment had been made in community-based care for people with mental disorders other than post-traumatic stress disorder (PTSD).

There were – and still are – numerous agencies providing various types of emergency mental health and psychosocial support. Despite the diversity, two types of support have dominated: the first directed towards the adverse psychological effects of traumatic events, and the second focused on strengthening community-based social supports to improve psychosocial well-being (an interest of child protection agencies). A few NGOs provided specialized care for people with mental disorders, but mainly for survivors of traumatic events.

Planning for reform during an emergency

Following the start of the second intifada in 2000, renewed international attention and donor support were focused on mental health in the West Bank and Gaza Strip. In 2001, the World Health Organization (WHO) conducted an initial assessment and soon thereafter started working with the MOH to provide assistance on mental health reform. Meanwhile, the Governments of France and Italy also made major commitments to strengthen community mental health care in the territory. To address the risk of duplication and fragmentation between these agencies, WHO initiated development of a technical agreement signed by the MOH, the Consulates of France and Italy, and WHO. This agreement committed the partners to work together to

implement a common vision for mental health care (see Box 1). A steering committee on mental health – consisting mainly of Palestinian mental health and public health professionals – was appointed by the MOH to develop the mental health plan.

In early 2004, the MOH adopted the committee's 5-year Strategic Operational Plan. The plan emphasized: (a) establishment of geographical area-based mental health service systems, with each defined area having a community mental health service consisting of a community mental health team and centre, acute inpatient beds, day care services, rehabilitation, and continuing care accommodation, and means to respond to the mental health needs of children and older people; (b) redistribution of mental health service resources, particularly from psychiatric hospitals, across the territory; and (c) collaboration with other sectors, including the NGO sector.

The work of the MOH and WHO towards implementing the plan was not funded continuously. The European Community Humanitarian Office (ECHO) provided intermittent support in earlier years. In 2008,



Photo 2. Recently displaced Palestinians in the West Bank.
Photo: © Zahra Moloo/IRIN. Reprinted with permission.

Box 1. Division of responsibilities according to the 2003 agreement between the Palestinian Authority's MOH and the Consulates of France and Italy

- The Ministry of Health (MOH) will formulate the mental health policy, will be the focal point for coordination among involved parties, and will give the necessary political commitment to the partners in the implementation of their projects. The MOH will appoint a steering committee.
- The World Health Organization (WHO) will support the MOH to formulate the mental health policy, will provide the scientific justification to reshape the National Mental Health Policy (NMHP), will assist the MOH in providing guidelines, protocols, and standards, will support the MOH to analyse information and to address mental health research, and will assist the MOH in coordinating donor support.
- The Consulate General of France will be committed to comply with the MOH mental health policy. It will support the implementation of the NMHP through implementing a specific project focused on mental health. The project will include long-term training in France for new psychiatrists, short-term local training for primary health workers, piloting community mental health centres, research, and conferences.
- The Consulate General of Italy will be committed to comply with the MOH mental health policy. It will support the implementation of the NMHP through implementing a specific project focused on mental health. The project will include formulating mental health legislation, hosting short-term study tours in Italy for senior mental health workers, piloting community mental health centres, research, and conferences.

implementation was accelerated by a 3-year project contract awarded by the European Commission (EC). Project activities were designed to support the plan, mainly via capacity building in the MOH and among health workers, and also through community education and support of user and family associations.

Progress to date

Reform has affected mental health care at primary, secondary, and tertiary levels. Good progress has been made towards establishing a number of community mental health centres in the West Bank. Since 2004, 10 new centres have opened across the area, funded by a range of donors. Centres have been constructed by WHO, Agence Française de Développement (AFD, the French Development Agency) and the United Nations Development Programme

(UNDP), and Médicos del Mundo (MDM Spain, Doctors of the World Spain). As part of the AFD/UNDP project, a pilot community mental health centre for children and adolescents and a resource centre have been established. Six community mental health centres are operational in the Gaza Strip; each centre is staffed by at least one mental health team. Across the West Bank and Gaza Strip, the number of people managed in community mental health centres has clearly risen (see Figure 1).

Psychiatric hospitals are also being reformed. In the Gaza Strip, the mental hospital is planned for closure, with acute care beds to be added to general hospitals. Bethlehem's psychiatric hospital in the West Bank has been slowly reducing the number of beds for people staying for long periods (see Figure 2). It has developed outpatient services, occupation-

al therapy, and support to a family association. In addition, the hospital is developing a vocational rehabilitation programme.

Training in mental health for health workers in primary care clinics and community mental health centres has been conducted through different programmes. MOH general practitioners and nurses in both the West Bank and Gaza Strip have received initial training on the management of mental disorders in primary care. International Medical Corps, the Juzoor Foundation, the Gaza Community Mental Health Programme, Médicos del Mundo Spain, and Médecins du Monde (France) have also been training primary health care workers. Community mental health centres are now better able to manage mental health disorders, and primary care clinics are beginning to play a role in the diagnosis and management of common mental health problems.

Additional support is needed to consolidate these developments, in particular to continue the training and supervision of general practitioners and nurses

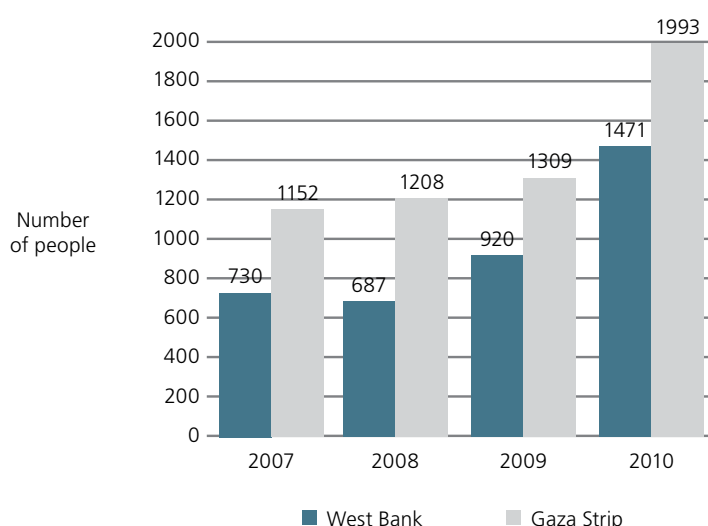
working in primary care, to further implement the primary care approach to service delivery. Clear referral, back-referral, and linkage systems are still needed to connect health workers at all service levels.

Overcoming ongoing challenges

The occupation and intermittent conflict are ongoing: economic hardship, repeated violence, and human rights violations are commonplace realities for many Palestinians. New cases of mental health problems continue to arise as a result of violence and loss. These needs must be considered alongside the normally expected volume of mental disorders. Building a comprehensive mental health system to manage this range of needs has been challenging. Yet in the absence of significant political progress, entrenched vulnerabilities and a high burden of mental health problems will remain a reality.

Within this context, mental health services have continued to struggle with the physical and political separation between the West Bank and Gaza

Figure 1. Number of people managed in community mental health centres



Strip and the diverse mental health and psychosocial approaches of humanitarian health and protection agencies. The goal has been to establish a unified directorate of mental health to manage both community-based and hospital mental health services and oversee the public mental health system as a whole, ensuring continuity of care for users and carers and providing effective management and professional development. This has been achieved by the creation of a Mental Health Directorate in 2008 in Gaza but has not yet been achieved in the West Bank – although a Mental Health Unit has been established by the MOH in Ramallah to provide professional leadership and policy guidelines for mental health services.

Funding from the EC for the three-year project supporting WHO and the MOH expired in 2011 and, after a one -and- a half-year gap, a further phase of the EC-funded project commenced in 2012. Although challenged by the lack of skilled mental health staff and finances, the MOH and WHO are committed to continue with the reform.

Contributors

Hazem Ashour, Director of Mental Health, Ministry of Health, Palestinian Authority

Nargiza Khodjaeva, previously Technical Officer, WHO West Bank and Gaza; currently Project Manager, WHO Country Office in Uzbekistan

Dyaa Saymah, National Officer Mental Health, WHO West Bank and Gaza

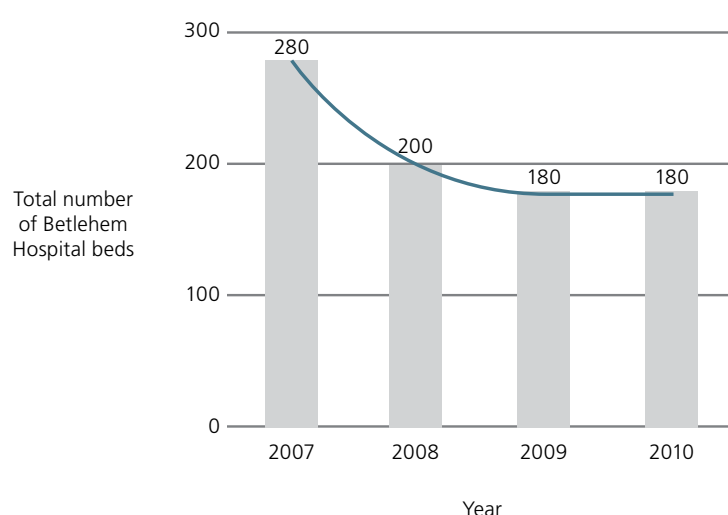
Rajiah Abu Sway, National Professional Officer, WHO West Bank and Gaza

Tony Laurance, Head of Office, WHO West Bank and Gaza

Acknowledgement

WHO would like to acknowledge the European Commission for its support to reform mental health care in the West Bank and Gaza Strip. WHO staff and consultants who have supported this project over the previous decade are gratefully acknowledged.

Figure 2. Number of inpatient beds, Bethlehem Hospital



Lessons learnt

The process of reforming mental health care in the territory illustrates several general points:

- Political commitment, a clear plan, and stakeholder consensus around that plan make it possible to reform mental health services in the midst of a complex, long-term humanitarian crisis.
- When conflict and unrest continue during the period of mental health reform, flexibility is required. Plans sometimes need to change to accommodate new circumstances. A balance must be achieved between choosing and implementing a limited number of priority topics on one hand, and undertaking comprehensive reform on the other hand.
- When new cases of mental health problems continue to arise as a result of violence and loss, these needs must be considered alongside the normally expected volume of mental disorders. This should not, however, be allowed to divert significant human resources from mainstream mental health service provision.
- Donors' funding cycles are frequently restricted to limited timeframes and have tended to prioritize emergency responses over sustainable development of the existing mental health system. Although this can challenge continuity, it does not need to stop mental health reform.

Related publications

De Val D'Espaux S et al. Strengthening mental health care in the health system of the occupied Palestinian territory. *Intervention*, 2011, 9(3): 279-290. (<http://www.interventionjournal.com/index3.html>, accessed 14 January 2013)

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Part 3.

Spreading Opportunity in Crisis: Lessons Learnt and Take Home Messages



More than half a million people have fled Syria for neighbouring countries, including Iraq. © Jodi Hilton/IRIN. Reprinted with permission.

The 10 case examples featured in this report (see sidebar) show that it is possible to make substantial gains in building and strengthening sustainable mental health services during and following emergencies. Some of the areas highlighted have endured or are still enduring prolonged armed conflict and political instability. Others withstood lengthy civil conflicts before being struck by a devastating natural disaster. One case describes a country coping with the rapid influx of large numbers of displaced people from a neighbouring country. Despite these variations, all were able to make exceptional progress in mental health system development, despite being faced with an emergency situation.

Beyond these broad comparisons, the sociopolitical and cultural context of each case varied widely. And for actors on the ground, seemingly minor details of their general and mental health systems were important.

While details differ, certain commonalities and overlapping practices can be found among these cases. These practices are consistent with the:

- guidance on comprehensive response in the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (1);
- guidance note on mental health early recovery in the Sphere Project's *Humanitarian Charter and Minimum Standards in Humanitarian Response* (2); and
- *Guidance Note on Early Recovery* by the Cluster Working Group on Early Recovery (3).

Selected achievements

Afghanistan: Since 2001, more than 1000 health workers have been trained in basic mental health care and close to 100 000 people have been diagnosed and treated in Nangarhar Province.

Burundi: From 2000 to 2008, more than 27 000 people were helped by newly established psychosocial and mental health services.

Indonesia (Aceh): In 2011, 13 out of 23 districts had specific mental health budgets (compared with no districts in 2004).

Iraq: Since 2004, 80–85% of psychiatrists, more than 50% of general practitioners, and 20–30% of nurses, psychologists, and social workers working in the country have received mental health training.

Jordan: New community-based mental health clinics helped more than 3550 people in need from 2009 to 2011.

Kosovo: Starting from a hospital-based model of care in 1999, community-based mental health became one of five priority areas within Kosovo's health policy, and a specific budget was allocated for the reform.

Somalia: From 2007 to 2010, chains were removed from more than 1700 people with mental disorders.

Sri Lanka: Prior to the 2004 tsunami, only 10 (37%) of the country's 27 health districts had mental health services infrastructure. Today, 20 (74%) offer a range of mental health activities, which are organized by staff based at acute inpatient units within general hospital settings. More than 771 mental health workers have been trained since the tsunami.

Timor-Leste: Building from a complete absence of mental health services in 1999, the country today has a comprehensive community-based mental health system. Mental health-trained general nurses are available in around one quarter of the country's 65 community health centres (compared with none in 1999).

West Bank and Gaza Strip: In 2010, more than 3000 people were managed in community-based mental health centres across the West Bank and Gaza Strip.

1. Mental health reform was supported through planning for long-term sustainability from the outset.

As demonstrated by several cases in this report, successful mental health reform commenced meaningfully in the midst of emergencies when an early commitment was made towards a longer-term perspective for mental health reform. Sri Lanka's government, for example, took a long-term perspective following the tsunami of 2004. Key leaders saw the possibility to enact broader mental health reform.

Part of sustainability is scalability. Short-term or pilot programmes (see point 9 below) should be tailored to the resource realities of the affected area and should bear in mind types and availability of health workers. In Jordan, three pilot community mental health centres have shown that secondary mental health care can be realistically offered across the country.

Donors have a role in planning for sustainability. Those who fund mental health services during emergencies should be prepared to facilitate the transition to funding for longer-term mental health reform. For example, international donors played an important role in facilitating the restoration and reform of Kosovo's mental health care system.

2. The broad mental health needs of the emergency-affected population were addressed.

Many cases in this report undertook reforms that addressed a wide range of mental health problems. Importantly, none established stand-alone (vertical) services for post-traumatic stress disorder (PTSD) that ignored other mental disorders.

A focus on broad mental health needs is important, because population rates of not only PTSD but of other mental disorders (such as psychoses, depressive and anxiety disorders, behavioural disorders, and alcohol and drug use disorders) increase after exposure to adversity. In addition, systems must be able to manage the ongoing needs and vulnerabilities of people with pre-existing mental disorders, as well as those who seek help for non-pathological psychological distress.

Timor-Leste, for example, now has a three-tier system of care. This system calls for primary care nurses to manage most cases, district mental health workers to provide specialist consultation as needed, and a psychiatrist to be responsible for the most complex clinical cases and overall clinical leadership. Across these settings, PTSD is managed alongside other mental disorders.

3. The government's central role was respected. During and following some of the emergencies described in this report, government structures were adversely affected, but humanitarian aid helped subsequently to strengthen them. In the West Bank and Gaza Strip, WHO has been supporting the Palestinian Authority's Ministry of Health to formulate a strategic operational plan for mental health, and has assisted in transforming services, training staff, and developing primary health care clinical protocols, among other functions.

In some situations, aid agencies have been known to bypass governments and create parallel systems of mental health service delivery. While understandable in some contexts, this practice carries the risk of undermining governments' ability to function sustainably. In addition, local professionals can be siphoned away from government service.

If government workers are overloaded, seconding staff can help strengthen capacity. This was the case in Afghanistan, where an expatriate mental health advisor was seconded to support the director of mental health and the drug demand reduction efforts of the Ministry of Public Health.

The government may also assign certain health functions to nongovernmental organizations, while maintaining an oversight role. The Government of Afghanistan decided to contract NGOs to provide certain health services, while the Ministry of Public Health concentrated on regulation and policy-making.

4. National professionals played a key role. Local professionals – even when they are few in number – can be powerful champions in promoting and shaping mental health reform. This was the case in Kosovo, where Kosovar neuropsychiatrists formed a task force that drafted a mental health reform strategy with the technical support of WHO and other partners. In Iraq, professionals living in the country and abroad provided essential support to establish the new mental health system.

International experts and agencies should involve themselves in mental health reform only if they are specifically invited to do so. International experts and agencies should be involved to the extent that they can commit themselves to sustained, long-term engagement and capacity building (4). If they become involved, it is important for international agencies to work with (groups of) local champions for mental health reform and to help strengthen their capacity as needed.

5. Coordination across agencies was crucial.

There is a well-known need for coordination of diverse mental health and psychosocial support activities during the acute phase of major emergencies (1). Coordination, however, is also crucial in the longer term, when working towards mental health reform. After the acute phase, coordination of such reform can be less difficult because the number of actors involved tends to be smaller, and the broad goals of the reform tend to be more easily defined. In Aceh, Indonesia, selected international agencies supported the government in a complementary manner to help build basic mental health services throughout the province in the years following the 2004 tsunami. In Iraq, a National Mental Health Council composed of representatives from numerous government sectors has served as an advisory board to the Ministry of Health. In the West Bank and Gaza Strip, a formal agreement between the Palestinian Authority's MOH, WHO, and government donor representatives of France and Italy committed the partners to work together towards a common vision for comprehensive mental health care. This helped to ensure coordinated international investments, with the partners complementing one another by taking responsibility for supporting different community mental health centres across the territory.

6. Mental health reform involved review and revision of national policies and plans.

Policies and plans provide coherence and legitimacy to mental health reform. As such, most cases featured in this report describe an overall process that involved national policy reform. Revisions of policy and plans took place during and after emergencies in Afghanistan, Burundi, Iraq, Jordan, Kosovo, Sri Lanka, and Timor-Leste, as well as in Aceh, Indonesia.

Drafting and adopting a government policy can take a long time, but in the context of disaster, when political will for mental health is high, the policy reform process can be accelerated. In Sri Lanka, the momentum created by the emergency situation facilitated rapid consensus building, which led to a new parliament-approved mental health policy within 10 months of the tsunami.

Although mental health-specific plans are important, it is also extremely useful to feature mental health as a part of a general health plan. This has been the case in Afghanistan, where mental health services are included within the country's Basic Package of Health Services and its Essential Package of Hospital Services.

7. The mental health system was considered and strengthened as a whole.

Many cases in this report describe processes that reviewed and assessed the formal mental health system as a whole following an acute emergency. Doing so provided an understanding of the overall system and how it was affected by the emergency; it also facilitated prioritization for programming. Once health planners assessed the overall system of care – as was done in Somalia – they were able to make informed decisions about where to focus new programmes, initiatives, and resources. Assessment tools such as WHO's Assessment Instrument for Mental Health Systems (WHO-AIMS; 5) and its adaptation in the new mental health assessment toolkit for humanitarian settings (6) can be used for this purpose.

Mental health systems as a whole should be strengthened to ensure that mental health care becomes accessible to people in the community. Good progress has been made towards establishing community mental health centres in the West Bank and Gaza Strip. Access to nearby services is especially important in this territory, because the mobility of its population has often been severely restricted. In Timor-Leste, a new community-based mental health system has been built with a strong emphasis on outreach and support for families. Kosovo, which traditionally offered only hospital-based mental health care, now has a range of outpatient service levels within each region.

To strengthen the health system, long-stay psychiatric hospitals often need to be downsized or re-purposed. Decentralization of mental health resources – staff, budgets, and beds – from tertiary care to secondary and primary care levels is a key strategy when organizing and scaling up cost-effective and humane treatment of people with mental disorders after an emergency.

Coordination with those responsible for constructing, reconstructing, or refurbishing general hospitals is important. In districts without specialized mental health care, plans for general hospitals should consider acute psychiatric outpatient and inpatient units, which can become the base from which staff organize a range of mental health activities in a district, as shown in Sri Lanka.

8. Health workers were reorganized and trained.

While the emergencies described in this report created major challenges for health planners, they also presented opportunities to reorganize and train health workers so that they were better equipped to manage mental health problems. Notably, investments in people and services outweighed investments in constructing or refurbishing buildings.

Reorganizing health workers often involves “task sharing” (also known as “task shifting”), which is the supervised process of moving mental health care functions from more to less specialized health workers. This was the case in Aceh, Indonesia, where nurses were trained to provide outpatient mental health care. They conduct home visits, ensure that people receive appropriate medication, and provide support to families. When needed, they refer people for short-term inpatient care, which is provided jointly by trained nurses and general practitioners and supervised by a psychiatrist from the provincial mental hospital.

In some of the reported cases, new types of health workers were created to fill health worker shortages and gaps. In Burundi, a new cadre of health worker – named psychosocial workers – provided a broad range of psychosocial services to individuals, families, and communities.

In Sri Lankan districts without psychiatrists, graduates of a new one-year diploma in psychiatry lead mental health care in districts under the supervision of a consultant psychiatrist based elsewhere. Another innovative mental health worker cadre in Sri Lanka is the Medical Officer of Mental Health, a medical officer with three months of psychiatry training. Finally, new community-level mental health workers, known as Community Support Officers, have been deployed in

tsunami-affected areas of the country. These workers identify and refer people with mental health problems in their communities and provide them with practical support.

Health workers who assume new functions and responsibilities for mental health must receive appropriate training. In Somalia, mental health has been incorporated into the training of a range of health workers. Importantly, health workers must receive regular supervision to help them consolidate their skills. In Jordan, a senior child and adolescent psychiatrist provides supervision to the multidisciplinary mental health team that manages these cases in a community-based setting. In Timor-Leste, international mental health professionals provided classroom-based training and spent extensive time in the field working side-by-side with Timorese colleagues.

9. Demonstration projects offered proof of concept and attracted further support and funds for mental health reform.

Demonstration projects – which may be completed using short-term emergency funding – can provide proof of concept and momentum for longer-term funding from donors. In Burundi, a small pilot project financed by humanitarian aid funds led to long-term programmes and much broader change. As mentioned above, newly established secondary care-level mental health services in Jordan demonstrated an alternative way of treating people with mental disorders. This supported the vision for establishing community mental health services across the country. In Sri Lanka, national and international investments in mental health have continued many years after the tsunami, because of the momentum created by visible success in a few districts.

Demonstration projects ideally should occur in the context of a broader and unifying mental health policy or plan (see point 6 above). This helps prevent the possibility of fragmented or piecemeal work across the affected area. This was the case in Kosovo, where the mental health strategic plan was the roadmap through which demonstration projects were coordinated.

Demonstration projects should be monitored and evaluated. With tangible proof of concept, the argument for scaling up becomes stronger.

10. Advocacy helped maintain momentum for change.

Almost all cases featured in this report describe individuals or groups who became successful advocates of broader mental health reform. They helped maintain momentum for change after the acute emergency was over. Depending on the specific case, advocates ranged from government officials to health workers and health professional groups, service users, national and international nongovernmental agencies, and well-known personalities within the country. Regardless of their station, all advocates used available information in deliberate and strategic ways to change perceptions and to influence decision-making.

Advocacy is most likely to be successful when diverse interest groups join together to circulate common messages and work in unified action. This happened in Iraq, in Aceh, Indonesia, and in Sri Lanka, among other locations. Their experiences show that advocacy is successful when people are informed about the issues, but also when they are asked to become part of the solution.

Conclusion

The cases featured in this report show that mental health reform is realistic as part of recovery, even in highly challenging circumstances. They also illustrate how the 10 practices summarized above were likely key in achieving success. These practices are not an exhaustive list of everything that can or should be done to promote mental health reform in emergencies (e.g. see also 7, 8). Actions must be contextualized for the particular circumstances of the country, bearing in mind resource availability.

Programme planners should seize the opportunity to use emergencies as a catalyst for mental health reform. Mental health – neglected for far too long – is crucial not only to people’s well-being, but also to the functioning and resilience of societies recovering from emergencies. Decision-makers are encouraged to review these cases to consider how the overlapping practices and lessons learnt can be applied in their own situations.

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“In my experiences working in areas ravaged by natural disasters and man-made catastrophes, I’ve found that emotional wounds can present obstacles just as daunting as the physical destruction. I’m grateful that in *Building back better* the World Health Organization is shedding new light on this important issue and explaining how creating sustainable mental health systems must be part of any long-term recovery in the aftermath of emergencies.”

President Bill Clinton

“Mental health is an important aspect of crisis recovery as I have personally experienced in a number of countries I have served. Indeed, the long-term cost to individuals and to societies’ development can even be greater than the immediate effects. This impressive publication rightly guides agencies to adopt a long-term approach to mental health care after crises.”

Neil Buhne

**Chair, IASC Global Cluster Working Group on Early Recovery
Bureau for Crisis Prevention and Recovery
United Nations Development Programme**

“Emergencies create critical opportunities to develop better health care systems for the long term. This book illustrates beautifully how colleagues in mental health – an important but thus far neglected area of health – have used the opportunity to ‘build back better.’ This publication goes beyond aspirational recommendations, providing proof of concept that it is sensible to invest in mental health systems after emergencies.”

Paul Farmer

**Founding Director, Partners In Health
Chair, Department of Global Health and Social Medicine
Harvard Medical School**

Emergencies, in spite of their tragic nature and adverse effects on mental health, are unparalleled opportunities to build better mental health systems for all people in need. This is important because mental health is crucial to the overall well-being, functioning, and resilience of individuals, societies, and countries recovering from emergencies.

Global progress on mental health reform will happen more quickly if, in every crisis, efforts are made to convert short-term interest in mental health into momentum for long-term improvement. *Building back better: sustainable mental health care after emergencies* shows how this was done in 10 diverse emergency-affected areas.

By publishing this report, the World Health Organization aims to ensure that those faced with emergencies do not miss the opportunity for mental health reform and development.



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